# Maternal and Child Health Services
# Title V Block Grant

# State Narrative for Pennsylvania

## Application for 2013
## Annual Report for 2011

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# Table of Contents

# I. General Requirements

## A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
***An attachment is included in this section. IA - Letter of Transmittal***

## B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

## C. Assurances and Certifications

The appropriate Assurances and Certifications (non-construction program, debarment and suspension, drug free workplace, lobbying, program fraud, and tobacco smoke) are signed and on file in the Director's Office of the Bureau of Family Health. They can be obtained by calling (717) 787-7192.

## D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

## E. Public Input

The Bureau of Family Health (BFH) has routine mechanisms in place to obtain public input and feedback on MCH programs that include but not exclusive to medical providers, advocacy groups, community partners, sister agencies and families. The following activities were linked specifically to the 2012 ***/2013/ 2013 //2013//*** application process to solicit public comments:

TBI Advisory Board
CSHCN Stakeholder Workgroup and Parent Forums
Web Postings
Public Project Planning Meetings via WebEX or in person
Mass Email Outreach
Public Notices
3 Public Comment meetings ***/2013/ One Public Comment meeting //2013//***
Ad-hoc Committees
Interim Needs Assessment with MCH Stakeholders

As stated above, three regional public comment meetings were held: April 12, 2011 in Wilkes-Barre, April 25, 2011 in Mechanicsburg, and April 28, 2011 in Altoona, Pennsylvania. The public comment meetings were held early in the process in order to allow time for input to be included in the 2012 Application. A summary of the Public Comment meetings is included in this application as an attachment. Full transcripts are available to the public upon request.

***/2013/ A public meeting was held May 23, 2012, in Harrisburg. The public comment meeting was held early in the process in order to allow time for input to be included in the 2013 Application. //2013//***

Public notification of a draft of the MCH Block Grant 2012 application was posted on the Department of Health's website from June 3 through July 1, 2011 and in the PA Bulletin. Additionaly, over 300 MCH stakeholders were notified of the posting via email.

***/2013/ Public notification of a draft of the MCH Block Grant 2013 application was posted on the Department of Health's website from June 4 through July 3, 2012 and in the PA Bulletin. Additionally, over 300 MCH stakeholders were notified of the posting via email. //2013//***

Interim Needs Assessment
The Division of Child Adult Health Services (CAHS) has engaged in a number of data collection and analysis activities including review and analysis of PRAMS data on bed sharing, pregnancy intendedness, low birthweight and barriers to obtaining prenatal care. A series of Data Briefs have been developed and made available to stakeholders. The DCAHS is also providing analytical support to the Pennsylvania Perinatal Partnership to explore areas of interest to the 7 Healthy Start projects in Pennsylvania and the 10 county municipal health departments. During the upcoming year, PRAMS data will be analyzed to assist in understanding the impact of the implementation of Act 73 of 2010, the Sudden Infant Death Syndrome Education and Prevention Program.

The DCAHS, as part of its efforts to expand services beyond lead intervention to include any health and safety hazards that arise in the home (the Healthy Homes approach), has staff who are analyzing data relevant to illness, disease, and injury in the home. In coordination with Health Statistics and other DOH and Department of Environmental Protection programs, staff have analyzed data from a variety of sources to determine priorities and target areas for services. Data regarding incidence or deaths from lead poisoning, asthma, cancer, and injuries such as falls, burns, poisoning, suffocation, and strangulation that occur within the home, as well as housing data and population data related to age, race, and income guided the process of program implementation. These data will continue to shape how the Healthy Homes programs deliver services to the citizens of Pennsylvania.

The DCAHS is working with three different institutions to conduct focus groups in an effort to better understand barriers women are experiencing in accessing prenatal care in selected zip codes in Philadelphia. This is part of the overall strategic program plan to implement a demonstration project to reduce infant mortality in Philadelphia. Data collection and analysis will be completed by June 30, 2011.

In 2011, the BFH formed a permanent advisory group, the MCH/PRAMS Advisory Committee. The BFH consolidated the former PRAMS Steering Committee and the former MCH Needs and Capacity Assessment Committee. The BFH has not had an advisory committee of this nature for several years. The newly formed advisory committee is comprised of family members, community members, county and municipal health departments, healthy start, academic community, community based agencies, and BFH upper management. The Committee will advise the BFH on issues related to the MCHSBG, priorities, performance measures, and other maternal and child health issues. The Committee will also recommend areas for analysis using PRAMS data and for the development of Data and Policy Briefs.

A copy of public meeting comments are attached to this application.

# II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

## C. Needs Assessment Summary

Efforts to bring the parent voice to the Bureau were successful in 2011 when staff found a mechanism to hire an individual as a part-time contractor through the State Implementation Grant. The employee, a parent of a child with a special health care needs, would work within the Bureau setting and at the Forum level to bring consistency and help implement the 6 priorities. In addition, the parent was responsible for assisting with the coordination of the second of two face-to-face meetings of the CORE Leadership team. Although the first meeting in October of 2011 was productive in moving ahead the development of the plan for children with special needs, the second in April of 2012, was more successful due to the representation of youth.

***/2013/ The Bureau of Family Health team members are beginning research this year to determine the most cost effective and efficient way to approach the 2015 5-year needs assessment. //2013//***

# III. State Overview

## A. Overview

In Pennsylvania, Title V dollars support county/municipal health departments, profit and non-profit organizations, universities, and community and tertiary hospital facilities in providing comprehensive adolescent health services, education and family support through home visiting programs, direct health services for children and children with special health care needs, information and referral services, primary and preventative care for children, teen pregnancy prevention programs, newborn hearing and metabolic screening and follow-up, lead poisoning prevention and testing, pediatric medical homes, needs and capacity assessments, outreach to children and their families, and postpartum depression services.

Geography

Pennsylvania is located in the Mid-Atlantic region of the United States. Pennsylvania has a land area of 44,817 square miles, placing it 33rd /2012/ 32nd //2012// among the fifty states. It is comprised of 67 counties, 56 cities, and 962 boroughs. Forty-eight of Pennsylvania's 67 counties are classified as rural according to the Center for Rural Pennsylvania.
Approximately 28% ***/2013/ 21% //2013//*** of the state's population live in the rural counties and 72% ***/2013/ 79% //2013//*** live in the state's 19 urban counties.

/2012/ Pennsylvania is comprised of 67 counties, 57 cities, and 966 boroughs (Commonwealth of Pennsylvania Municipal Statistics). //2012//

Government

Like the United States, Pennsylvania's government is defined by a constitution and is comprised of three equal and independent branches. The legislative branch makes commonwealth laws, a responsibility carried out by the General Assembly. The General Assembly consists of two bodies--the Senate (50 Senators) and the House of Representatives (203 representatives). The executive branch administers commonwealth laws and is overseen by the Governor. Finally, the judicial branch preserves the rule of law and guarantees citizens' rights by resolving disputes through the courts. The Governor's Office promulgates major program and priority changes. The budget for State Fiscal Year 2009-2010 was signed on October 9, 2009, 101 days after the start of the state fiscal year. Pennsylvania was the last state in the nation to have a signed budget. All States are currently facing one of the worst fiscal periods since the Great Depression and Pennsylvania is no different. Cost containment efforts in Pennsylvania include: 1) A general hiring freeze, followed by employee layoffs which reduced the state workforce by 4.8% between January 2003 and December 2009; 2) Out-of-state travel restrictions; 3) A ban on the purchase of new state vehicles (there are 500 fewer vehicles in the Commonwealth's fleet than last year); 4) A freeze on cabinet and non-union employees' salaries-they have not seen an increase since July 2008; and 5) Budget reductions. One hundred forty-two (142) of the 657 line items in last year's budget were completely eliminated this year. Another 360 line items were reduced. In addition to the reduced budget, on February 18, 2010 the Governor enacted another 1% reduction of all General Fund appropriations, reducing the budget again by $128,374,000. Pennsylvania is the only major industrial state in the nation found to be fiscally sound, ranking 7th in the nation for fiscal stability, tied with the much smaller state of Utah.

/2012/ Pennsylvania's Government currently faces the challenge of a $4.16 billion deficit, with a $63.6 million operating expense. Like most other states, Pennsylvania is facing a protracted economic recovery that will take considerable time and effort to work through the $4.16 billion deficit. The 2011-12 proposed General Fund budget for Pennsylvania is $27.3 billion, a decrease of $866 million, or 3.1 percent, from year 2010-11. Overall, state spending is to be reset at near 2008-09 levels. The 2011-12 proposed budget eliminates 103 appropriation line items -- cutting nearly $850 million in annual spending. It reduces funding for more than 150 appropriations and consolidates an additional 55 appropriations with the intent to streamline government. Although Pennsylvania's economy has fared better than the economies of many other states, the

Commonwealth's social safety net needs to be protected to help children, families and vulnerable adults in tough economic times. According to Governor Tom Corbett , inaugurated as the Commonwealth of Pennsylvania's 46th Governor on January 18, 2011, the proposed 2011-12 budget refocuses the investment of tax dollars in the core functions of government, and it consolidates and streamlines economic development programs to create jobs and attract businesses to Pennsylvania.

The 2011-12 budget supports programs to our most vulnerable citizens and to those most in need. It focuses efforts on the core functions of our health and human services programs. However, the national economy continues to exert significant pressures on the state budget. This budget supports critical programs to move people toward self sufficiency, while redirecting and resetting all programs to achieve that mission. As a result of continued financial pressures, this budget redirects funding in the Department of Health to key core functions including: quality assurance of the health care delivery system in Pennsylvania, treatment and services for rare disease management, emergency preparedness, special medical programs, cancer screening, newborn screening and maternal and child health programs. Funding for the Department of Health is now structured to support direct services and primary core functions critical to the public health infrastructure and where appropriate will integrate education and outreach into service delivery, including drug and alcohol treatment programs.

The Commonwealth has been involved for a number of years in multiple strategies to improve services, allow for more choices, rebalance the service delivery system, transition people off of the welfare system and manage care effectively even with these programs, waivers and system design efforts. However, the Commonwealth has not been successful in effectively reforming programs to focus on competition, prevention, wellness, employment first, integrity, personal responsibility, choice, consumer empowerment and independence. This budget initiates efforts to establish an integrated, coordinated and seamless service delivery system that addresses consumer needs for quality, independence, flexibility and service coordination while addressing the need for cost containment and financial integrity.

The 2011-12 proposed  budget contains a number of cost-containment initiatives that address the quality of care and care management for clients, smart purchasing, program integrity and fair share payments. Initiatives in this budget seek to encourage more home and community-based care in our long-term care, child welfare, mental health and intellectual disability programs to achieve a better quality of life for clients and significant programmatic savings. Care management plan administration will be redesigned to incentivize personal responsibility, prevention and wellness to curb the high costs of health care while maintaining high quality levels of care. //2012//

***/2013/ The Commonwealth continues to work through financial issues resulting from lower tax revenues over the last couple of years, but has been closing the gap in projected shortfalls.  The 2012-13 proposed budget lowers spending less than a tenth of a percentage point from FY 2011-12.  Given the constrained fiscal environment, with no new taxes to families, the budget includes steep cuts to higher education.  The proposal also includes reforming of the public welfare system by providing incentives to have people move from public assistance to the workforce.  //2013//***

Population
Pennsylvania ranks 6th as the most populated State in the country with an estimated population of 12,604,767 people for 2009 (Pennsylvania State Data Center's Pennsylvania Facts 2010) and a population density of 281 persons per square mile.  The population is diverse in geography, age, race, culture, and linguistic make up.
/2012/ Pennsylvania ranks 6th as the most populated State in the country with a current estimated population of 12,702,379, exhibiting an increase of 3.4 percent (421,325 total persons) since the last Decennial Census (April 1, 2000). //2012//

The gender distribution is 51.3% female and 48.7% male. Of the state's 12.6 million residents, approximately 22.2% are under the age of 18; 62.5% are 18 to 64; 12.8% are 65 to 84; and 2.5% are 85 and older. Pennsylvania's population has the 3rd highest proportion of people 65 and older in the United States. The median age of Pennsylvania residents is 40 years of age.
/2012/ The gender distribution in 2010 was 51.4% female and 48.6% male. Of the state's 12.7 million residents, approximately 22% are under the age of 18 and 78% over 18 years according to the Pennsylvania State Data Center. Median age of Pennsylvania's population is 41.5 years (The Center for Rural Pennsylvania). //2012//

/2012/ In 2009, The Center for Rural Pennsylvania affirms 15.4 percent of the State's population was 65 or older. The elderly population is less diverse than the overall population: 90.3 percent of persons 65 or older were White alone, Non-Hispanic (compared to 80.9 percent for the state as a whole). Over one quarter of all Pennsylvania households included one or more persons 65 or older.

Philadelphia (1,526,066), Allegheny (1,223,348), and Montgomery (799,874) remain Pennsylvania's most populous counties. Together, these three counties make up over one-quarter (27.9 percent) of the state's total population. Cameron (5,085), Sullivan (6,428) and Forest (7,716) have the smallest populations. //2012//

/2012/ Education
The total school enrollment in Pennsylvania was 3.1 million in 2005-2009 according to the Pennsylvania State Data Center. Nursery school and kindergarten enrollment was 336,000 and elementary or high school enrollment was 1.9 million children. College or graduate school enrollment was 861,000. In 2005-2009, 87 percent of people 25 years and over have at least graduated from high school, and 26 percent had a bachelor's degree or higher; 13 percent were dropouts, not enrolled in school or had not graduated from high school.

State academic assessments show that over one quarter of all Pennsylvania public students perform below standard in reading and math. Studies have found that 45 percent of Pennsylvania high school graduates received a diploma without meeting standards, while 30,000 students drop out each year, never earning a diploma at all. Though our students have demonstrated some academic gains, Pennsylvania as a whole has failed to show sustained student achievement growth, results supported by national assessments of educational progress. The challenge is clear: Pennsylvania must make our schools more competitive and continuously improve their quality and do so even in the most challenging fiscal environment in recent history.

The proposed 2011-12 budget provides over $8.6 billion in support of local public schools, an amount Pennsylvania taxpayers can afford and state government can sustain. Basic Education Funding (BEF), the largest single line-item in support of public education, is funded at $5.226 billion. This level matches the funding provided in the 2008-09 budget, prior to the $1.7 billion in temporary funding from the American Recovery and Reinvestment Act (ARRA) of 2009 that was provided to public schools over the past two years and is no longer available. The $5.226 billion funding level is 28 percent greater than the 2002-03 BEF funding of $4.086 billion, and translates into a 2.8 percent growth rate over the past 10 years. The budget also maintains funding for other core basic education programs such as Special Education, Early Intervention, Career and Technical Education, Pre-K Counts, Head Start Supplemental Assistance, and Pupil Transportation, all of which are funded at or close to 2010-11 funding levels. //2012//

***/2013/ Total school enrollment was 3.2 million in 2010 according to the 2010 US Census Bureau. Of Pennsylvanians aged 25 or older, 88.4% had a high-school diploma, while 27.1% had a Bachelor's Degree or higher. //2013//***

Race and Ethnicity
Pennsylvania's largest minority groups are African-Americans, Hispanics and Asian-Pacific Islanders. African-Americans comprise 10.8% of the state's population, while the Hispanic group

which can span more than one racial category accounts for 4.8% and the Asian-Pacific Islanders account for 2.4%. Since 1991, refugees from over thirty countries have resettled in the Commonwealth, representing diverse ethnic, cultural and religious backgrounds. According to the Pennsylvania Refugee Resettlement Program, 2,203 refugees resettled in Pennsylvania between October 2008 and September 2009. Most were from Bhutan (785), Burma (456) and Iraq (416). The mission of the Refugee Resettlement Program is to help refugees and their families obtain employment, economic self-sufficiency and social integration within the shortest possible time after their arrival into the Commonwealth. Some of the services we provide to these multicultural immigrants include: 1) Special Supplemental Nutritional Program for Women, Infants and Children; 2) newborn screening and follow-up for metabolic conditions; and 3) genetic counseling.

/2012/ Five percent of the people living in Pennsylvania are foreign born. Ninety-five percent are natives and of those 75 percent were born in Pennsylvania.

Pennsylvania's Hispanic population is the fastest-growing minority group in the state. The population (of any race) who is Hispanic or Latino grew by 82.6 percent between 2000 and 2010, an increase of 325,572 people and accounting for 5.7 percent of the state's population. While the Hispanic population is the fastest-growing of the minority groups in Pennsylvania, it is not the largest: the Black or African Single race groups have 1,377,689 people, encompassing 10.8 percent of the state's total population.

The change in the Hispanic population is occurring in all parts of the state, but the largest percent population increases are concentrated in the Eastern half of the state. The counties with Hispanic population below the state's average are largely contained in the Western half of the state. The largest numeric increase in the Hispanic population among Pennsylvania counties is in Philadelphia County, which increased by 58,683. Lehigh and Berks counties saw the next-largest numeric increase in their Hispanic population, growing by 33,734 persons and 30,998 persons, respectively (Pennsylvania State Data Center). //2012//

***/2013/ Pennsylvania has the 4th highest proportion of people 65 and older in the United States (Pennsylvania State Data Center) //2013//***

Income

According to the Economic Outlook for 2010-11 in the Governor's Budget Address, Personal income growth experienced annual declines in 2008 and 2009, declining 0.4 percent and 1.6 percent, respectively. Despite rising unemployment, growth in real personal income is expected to rebound in 2010, growing 1.7 percent annually. Stronger personal income growth is forecast from 2011 through 2013 as unemployment eases. The Commonwealth's economic performance is largely dependent upon job growth. Since December 2007 and the start of the national recession, Pennsylvania has lost more than 212,000 jobs. In December 2009, the Commonwealth's unemployment rate was 8.9 percent, its highest level since August 1984. The national unemployment rate for December 2009 was 10 percent. Pennsylvania's unemployment rate has now been equal to or below the national average for 83 of the past 84 months.

The inverse relationship of the U.S. and the Commonwealth growth in personal income has re-emerged during the current recession. As the current recession has deepened, the rate of growth in real personal income plunged for the nation as a whole, as it did for the commonwealth. However, the decline in the rate of growth was less severe for Pennsylvania than for the rest of the nation. In fact, the Commonwealth ranked 12th in the nation in terms of the percent change in personal income during 2008. Economists expect that the rate of growth in Pennsylvania real personal income will exceed the national average in 2011 and 2012.

/2012/ Pennsylvania ranked 25th in the nation in terms of its rate of growth in personal income during 2010. The Commonwealth's growth in real personal income mirrored that of the nation at approximately 1.2 to 1.3 percent. //2012//

This strong performance is partially the result of the diversification of the Pennsylvania economy and a stronger state labor market. The growth of less recession-prone industries such as health care, pharmaceuticals, education and government has aided the commonwealth.

The short-term outlook for Pennsylvania is that its economy remains heavily dependent on the national economy. The Commonwealth actually outperformed the national economy during 2008, growing at an annual rate of 1.1 percent while the national economy grew at a rate of only 0.4 percent. Similarly, during 2009, the state economy again outperformed the national economy by recording a lower loss -- negative 2.0 percent for the commonwealth versus negative 2.5 percent for the broader U.S. economy. Beginning in 2010 through 2012, the gap between the two rates of growth is expected to re-emerge as the national economy expands.

/2012/ The median income of households in Pennsylvania was $49,737 in 2010. Seventy-seven percent of the households received earnings and 20 percent received retirement income other than Social Security. Thirty-one percent of the households received Social Security. The average income from Social Security was $15,386. These income sources are not mutually exclusive because some households received income from more than one source.

Based on data from the United States Census American Community Survey for 2007 - 2009, an estimated 5.5% of Pennsylvania's population was living below 50% of the federal poverty level, 12% was living below the 100% federal poverty level, and 29.2% was living below the 200% federal poverty level. These numbers represent a slight increase in all levels from the previous reporting year. //2012//

***/2013/ Based on data from the 2010 US Census Bureau the poverty level in Pennsylvania was 13.4%, with the majority being children under 5 years of age. //2013//***

Employment
Since peaking in December 2007, nearly eight million jobs have been lost nationally. Job losses, declines in household wealth and tighter credit are just a few of the factors adversely affecting consumer spending. The unemployment rate in Pennsylvania is 9.1 percent, and the average unemployment check in Pennsylvania is approximately $310.

Pennsylvania's fiscal year 2009 job losses were lower than the national average, and remained less steep than those of the surrounding states of New Jersey, Delaware and Ohio. Further, among the ten largest states, only Texas, New York and Pennsylvania lost jobs at rates lower than the national average.

Employment in the commonwealth saw job losses across all sectors in 2009 except for the educational and health services sectors -- which had job growth of 2.0 percent in 2009 and the government sector -- which had job growth of 0.1 percent in 2009. The manufacturing and information technology sectors had the worst year-over-year rate of job losses in 2009, with manufacturing jobs down 10.3 percent and information technology jobs down 6.6 percent. The construction, natural resources and mining; financial services; and professional and business services sectors also saw significant job losses in 2009, with each sector experiencing year-over-year job losses in excess of 5.4 percent.

The Pennsylvania Unemployment Rate for March 2010 rose from 8.9 percent to 9 percent, according to the Pennsylvania Department of Labor & Industry. The rate was up 1.5 percentage points from March 2009. The national unemployment rate is 9.7 percent. In February, the most recent month for which national figures have been released, the rate was 9.8 percent.

The annual change in employment levels in Pennsylvania is forecast at around -0.4 percent in 2010, while positive job growth is expected to return in 2011 at a rate of 1.5 percent annually. Slightly more robust job growth is forecast for the commonwealth in 2012, with job growth forecast at 2.2 percent. As the national economy begins to recover in 2010, the rate of job growth

in Pennsylvania is expected to again lag behind the national average. Total job losses for the Commonwealth are expected to reach 231,000.
/2012/ The U.S. employment growth is expected to be 1.3 percent in 2011. //2012//

/2012/ According to forecasts from IHS Global Insight, the Commonwealth's unemployment rate is expected to decline to an average 8.1 percent during 2011. Employment levels in Pennsylvania are not expected to surpass the prerecession peak of 5.811 million until mid-2012, according to current forecasts.

During 2010, the Commonwealth percent change in employment was good enough to move the state up to 13th nationally. Pennsylvania has traditionally been around 40th or below in this ranking, particularly during periods of strong job creation. The comparatively strong ranking, however, is somewhat deceptive: While the state does not generally produce as many new jobs when the economy is going strong, the Commonwealth also does not suffer as much as the rest of the country as a whole during periods of economic contraction.

The most common employment occupations in Pennsylvania are: Management, professional, and related occupations, 35 percent; Sales and office occupations, 26 percent; Service occupations, 16 percent; Production, transportation, and material moving occupations, 14 percent; and Construction, extraction, maintenance, and repair occupations, 9 percent. Eighty-two percent of the people employed were private wage and salary workers; 12 percent were Federal, state, or local government workers; and 6 percent were self-employed in own in non-incorporated businesses. //2012//

***/2013/ The number of working Pennsylvanians as of the 2010 US Census was 6,340,000 with an unemployment rate of 8.7%. Of the workforce, 88.3% of the workers had some type of health insurance coverage, with the majority of that being private health insurance. Of the unemployed, only 59.6% had some type of health insurance coverage. //2013//***

Housing
The United States housing bubble had an economic affect on the housing market in almost every state. A decline in housing construction and housing finance has, in part, led the economy into a recession. Until the housing markets stabilize, any recovery will be uneven.

/2012/ The United States Census Bureau reported in 2005-2009, a total of 5.5 million housing units in Pennsylvania, 11 percent of which were vacant. Of the total housing units, 75 percent were reported to be single-unit structures, 20 percent were multi-unit structures, and 4 percent were mobile homes. Sixteen percent of the housing units were built since 1990. The average household size was 2.5 people.

Families made up 66 percent of the households in Pennsylvania. This figure includes both married-couple families (50 percent) and other families (16 percent). Nonfamily households made up 34 percent of all households in Pennsylvania. Most of the nonfamily households were people living alone, but some were living in households in which no one was related to the householder.

The median monthly housing costs for mortgage owners was $1,359, non-mortgaged owners $454, and renters $716. Thirty-two percent of owners with mortgages, 17 percent of owners without mortgages, and 47 percent of renters in Pennsylvania spent 30 percent or more of household income on housing. //2012//

For all of 2010, residential construction is expected to grow just 5.8% on an annual basis. Further, sales of existing homes rose in 2009 for the first time in four years. Still, median existing housing prices plunged more than 12% last year. Overall median existing housing prices are expected to continue to grow minimally in 2010 and 2011, at annual rates of 1.3% and 1.2%, respectively. Pennsylvania has a balanced economy based on government, higher education and healthcare. The construction industry in Pennsylvania is stronger and unemployment is lower

than the national rate. Pennsylvania did not have the housing boom or as much speculation, therefore it was not affected as severely as most other states. Continuing threats to the housing crisis are unemployment, elevated vacancy rates, record foreclosures and the end of the homebuyer tax credit.
/2012/ During 2010, new housing starts rebounded in the Commonwealth growing to nearly 20,000 -- or a 21.2 percent increase from the prior year. Economic forecasts project that housing starts will continue to grow in 2011 at an annual growth rate of 14.7 percent, followed by more robust growth of 27.8 percent in 2012. The rate of sales of existing homes, which declined by 17.5 percent during 2008, slowed to an annual decline of 0.2 percent in 2009. Sales of existing homes weakened further during 2010, declining 7.7 percent from the prior year. Economic projections indicate a slow start to a sales rebound, with growth of 1.5 percent forecast in 2011, followed by stronger growth projected in 2012 through 2014. //2012//

/2012/ The Commonwealth ranks 29th in the country in loans and in foreclosures, and 40th in the nation in terms of new loan foreclosures initiated in 2010. While home prices had been falling dramatically throughout the nation, home price appreciation in Pennsylvania has essentially stalled from 2007 to 2010. Home prices in the Commonwealth are forecast to decline minimally in 2011 before home values begin to appreciate in 2012. //2012//

## B. Agency Capacity

The Bureau of Family Health, as the State Title V Agency in Pennsylvania promotes and protects the health of pregnant women, infants, children and children with special health care needs, through education, health promotion, treatment services, food benefits and access to health care. Every day, the Bureau strives to improve the health care and nutritional needs of Pennsylvania families. The Bureau, through its Division of Child and Adult Health Services, Newborn Screening and Genetics, Community Systems Development and Outreach, Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Operations, demonstrates capacity to promote and protect the health of all mothers and children, including children with special health care needs, through a variety of direct health care, population based, and enabling services.

The Division of Child and Adult Health Services

The Division of Child and Adult Health Services is responsible for many facets of maternal, child and infant health, from building and sustaining infrastructure to the provision of direct health services, population based services and enabling services. Title V dollars are used to support a variety of efforts including: reducing and eliminating infant mortality and the racial and ethnic disparities associated with these deaths, childhood lead poisoning prevention, family planning, teen pregnancy prevention, home visitation programs for pregnant and postpartum women, prevention of shaken baby syndrome, SIDS and infants deaths caused by suffocation or strangulation resulting from unsafe sleep practices, primary and preventative care services for infants and children, case coordination and case management for children with special health care needs, child death reviews, school re-entry for children and adolescents impacted by traumatic brain injury, and prenatal care for uninsured women.

Despite consistent programming, there remain significant concerns such as infant mortality, low birth weight babies, teen pregnancy, children who are lead poisoned, high risk adolescents who do not have a primary care physician, a medical home, or a place where they feel safe getting health care, and children who lack health insurance. Many of these health status indicators demonstrate significant health disparities. For example, in 2008, the state rate of infant mortality (per 1000 live births) was 7.3 for all births. However, the rate for black infants was 14.4 per 1000 live births. The overall percentage of women receiving prenatal care in the 1st trimester in 2008 was 79.4% while the percent of African American women was 64.1% and 67.2% for Hispanic women. For teens, in 2008, the rate of pregnancy for 15-17 year olds in Pennsylvania was 24.4

per 1,000; however, for African American and Latina teens, the rates were significantly higher (75.5 and 66.2 respectively).

One new model that the DCAHS will be working with all vendors to implement is the evidence-based Life Course Model. The Life Course Health Development Model emphasizes that early experiences, including both risk and protective factors, affect later health. To be a bit more specific, the model suggests that the interplay of biological, behavioral, psychological and social protective and risk factors contribute to health outcomes across the span of a person's life. So, for example, disparities in birth outcomes such as low birth weight, and infant mortality are often explained by the quality and frequency of prenatal care. In contrast, the Life Course Model suggests that these disparities result from differences in protective and risk factors between groups of women over the course of their lives. As a result, the health and socioeconomic status of one generation directly affects that health status of the next one. Examples of Protective and Risk Factors include: SES, race and racism, health care, disease status, stress, nutrition, weight status, birth weight, education, and housing. There is also a concept known as "weathering" which refers to life events that wear and tear on a person over time. "Weathering" is also a risk factor. It is widely accepted that over the course of a women's reproductive course, African American women have far more risk factors, and far few protective factors and these are correlated linearly with birth outcomes.

In addition to the Maternal and Child Health Services Block Grant, the DCAHS is also responsible for the administration of several other federal grants including: Housing and Urban Development Lead Hazard Control Program and the Healthy Homes Program; Centers for Disease Control and Prevention Childhood Lead Poisoning Prevention and the Pregnancy Risk Assessment Monitoring Systems; Health Resources and Services Administration Traumatic Brain Injury State Grants Program, Implementation Partnership Grant.
/2012/ Health Resources and Services Administration Traumatic Brain Injury State Grants Program, Implementation Partnership Grant and the Personal Responsibility and Education Program (PREP). //2012//

The Division of Community Systems Development and Outreach

The Division is responsible for several initiatives within the Bureau. These include the State Lead Program, grants providing education and advocacy on epilepsy and Tourette Syndrome, increasing breastfeeding initiation and duration rates, and a major focus on children and youth with special health care needs through such efforts as the Special Kids Network helpline at the Health and Human Services Call Center, the Special Kids Network System of Care Program, implementing a State Implementation Grant for Integrated Services for Children with Special Health Care Needs (SIG), and building the state's capacity for pediatric medical homes.

A guiding factor for the Division over the past years has been the previous work of the Children with Special Health Care Needs Stakeholder Group Recommendations. This diverse group of individuals came together at the request of the Department to generate recommendations that would give direction for improving services for children with special health care needs and their families. Since that time, the Division has made strides in addressing each of the key focus areas recommended for action by the group. Data involves providing meaningful information to support funding, programmatic and policy decisions; transition through adulthood; screening for special health care needs early and continuously; family centered care approach to involve families and youth in planning, delivery and evaluation; and home visiting for low income women at risk for poor birth outcomes. Activities in these key focus areas have been woven throughout the work of the Division and reflected within the National Performance Measures that address children with special health care needs (2, 3, 5 & 6).

The State Lead Program resides in the Division of Community Systems Development and Outreach. The program provides free lead abatement training at the Lead Abatement Training Center in Danville, PA to all non-profit and government employees in the Commonwealth. The

program conducts outreach events to promote the dangers of childhood lead poisoning and safe and accepted work practices for lead abatement and renovation work. The program also provides oversight of the toll-free Lead Information Line, which is responsible for the dissemination of information on lead paint dangers and poisoning prevention, as well as accepted safe work practices. Information is provided via telephone and website. The program is funded by the Environmental Protection Agency and is not Title V Block Grant funded.
/2012/ The program now provides free lead abatement training at select partner sites statewide. //2012// ***/2013/ Training participation increased by 17.0% over the previous year due to the use of the selected partner training sites. The partner sites will continue to be utilized in 2013. //2013//***

The Special Kids Network System of Care program works to address barriers and challenges families experience when trying to secure services for their children or in just trying to help their children lead full, productive and healthy lives. Department of Health employees, called Family Health Nursing Services Consultants, are located throughout Pennsylvania and provide the support for the activities of the Special Kids Network System of Care program. System of Care focuses on four main components: Community Systems Development (creation or enhancement of services); Community Mapping (developing a strength and gap analysis of communities regarding CYSHCN); Statewide Initiatives (addressing issues pertinent to most or all CYSHCN) and Outreach (building awareness and support for program goals). The System of Care web portal provides yet another source of information and resources for parents of CYSHCN, advising them of events and service providers available in their communities, and providing links to other organizations and programs.

/2012/ Staffed by the Department of Health's Program Administrators, along with the Family Health Nursing Services Consultants (FHNSC) located throughout Pennsylvania, SKN SOC provides regional community-based services for families of children and youth with special health care needs (CYSHCN). These services include Community Systems Development, Resource Mapping, Statewide Initiatives and Outreach, as well as the SKN Information and Referral help line, and the PA Recreation and Leisure Line, both of which connect families and CYSHCN to needed services. The SKN SOC web portal provides yet another source of information for parents of CYSHCN, advising them of events and resources available in their communities, and providing links to other organizations and providers. //2012//

Families of children and youth with special health care needs in Pennsylvania continue to express the need for access to services and comprehensive information. In a continued response to this need, the Division of Community Systems Development and Outreach has supported the "one call "concept for information and referrals through the Health and Human Services Call Center (HHSCC) since 2004. Four of the ten helplines (Healthy Baby, Healthy Kids, Special Kids Network and Recreation & Leisure) are funded by the Maternal and Child Health Block Grant (MCHBG), as is the System of Care helpline and web portal, which was recently added through the support of the contractor. Callers can obtain information about caring for their baby, applying for Medical Assistance or other insurance, and locate assistance for a child with a special need all on the same call. The Call Center continues to expand the number of resources in its resource database, has a web presence and recently added a live email chat feature and the HelpinPA Facebook page, providing new ways in which families can reach out for assistance. During the past fiscal year, the call center has provided 8,572 live chats through its website, and between May 1, 2010 and June 21, 2010, the call center has accumulated 275 fans on its Facebook page.

HHSCC has bilingual staff serving Spanish and Russian language callers, and has had access to 100 additional languages through interpretation services. A change to a new provider, Propio, for language services is hoped to provide better, faster access and opportunities for translation of fulfillment documents into languages other than Spanish. General program and health information materials are available in English and Spanish. Currently there is only one major fulfillment document translated to Chinese, the Healthy Baby booklet, which is a comprehensive guide for pregnant women and parents of infants. Outreach activities are conducted by HHSCC staff in

diverse communities to promote awareness of HHSCC services.

/2012/ DOH translated the Newborn Screening brochure into Russian, Spanish, Chinese, French, Portuguese and Vietnamese. The HHSCC has five bilingual staff serving Spanish and Russian language callers. In addition to the stated services for CYSHCN, calls to the Brain Injury and Lead Information help lines address head injury, traumatic brain injury, and residential lead-based paint hazard reduction acts and regulations.

In support of the National Performance Measures for MCH activities, and during calendar year 2010, the HHSCC received 962 calls and distributed 3,431 immunization fulfillment materials as well as 3557 English and 884 Spanish WIC brochures on the Healthy Baby and Healthy Kids help lines. HHSCC specialists referred 515 callers to prenatal care providers in their region; 11.45 % of these were for pregnancies in the first trimester. The Text4Baby program increased HB calls, opening the door to pregnant women and young parents to provide a healthier start for their infants. With training coordinated by WIC and CSDO, the HHSCC has eleven Lactation Specialists.

The HelpinPA Facebook technology offers the capacity for Bureau programs to promote information and to engage the public regarding health issues that affect them. //2012//

Pennsylvania's EPIC BEST Initiative (Educating Physicians in their Community Breastfeeding Support and Training) began in January 2009 following a year of planning, program research, and recruitment of trainers for the project which educated 50 physician practices in the Southeast and Southwestern areas of the state. The strategy was to increase the number of health care professionals who promote breastfeeding by providing evidence-based education, assistance, support, and community referrals to women who were pregnant. The funds that supported the project were from the Prevention Block Grant, an example of how our Bureau works collaboratively within the Department.
/2012/ The EPIC BEST Initiative ended due to lack of funding.

Pennsylvania's EPIC-IC Medical Home Initiative (Educating Practices in Community-Integrated Care) has received MCH Block Grant funding since 2002. The mission of EPIC is to enhance the quality of life for children and youth with special health care needs (CYSHCN) through recognition and support of families as the central caregivers for their child, effective community-based coordination, communication and improved primary health care delivery. The EPIC IC team has established a training program for primary care practices on the process of creating a medical home for all children including CYSHCN. Creating a medical home relies on seven components of care: accessible, family centered, comprehensive, continuous, coordinated, compassionate and culturally competent. //2012// ***/2013/ The EPIC BEST Initiative has been refunded effective July 1, 2012 for a two year period. The Initiative will have a similar format as previously utilized and is estimated to reach a minimum of 110 new practices with training and education on breastfeeding. //2013//***

Combined efforts under the State Implementation Grant have been designed to ensure that the Bureau becomes more family focused and engaged in meaningful partnerships with family and youth. A Parent Coordinator (parent of a child with special health care needs) was hired to convene a planning committee to generate ideas, build consensus and design a kickoff Consortium for CYSHCN conference. The work of the Consortium resulted in the implementation of regional parent, youth, and professional forums in six health districts in Pennsylvania. Key priorities identified by the forums were: access to community resources, increasing the number of medical homes, and transition to adulthood. Four parents of CYSHCN are engaged in comprehensive leadership training implemented by the Parent Education and Advocacy Leadership Center (PEAL). Once trained, the parents will assume leadership positions in the regional forums. To ensure that the service delivery and planning process is inclusive, we are conducting targeted outreach to families in communities with a large population of minorities and other cultural/ethnic groups that are under-represented at forum meetings. The youth voice is

equally important in this process and a Youth Coordinator (young adult with special needs) was hired and continues to lead youth activities including, convening Youth Development Leadership Institute's across the state to engage youth with special health care needs in leadership training. /2012/ In continued partnership with parents, youth and professionals, a select group of representatives from each of the six forums presented the overarching issues of concern to the Director of the Bureau of Family Health in November. Six priorities were determined most important for further action. Follow up meetings are planned for 2011. //2012//

One Delaware County educational health program that is influencing women of all ages is the new moms/new parents project for the First Time Motherhood Grant. The new moms/new parents' project is the only grant of this type in the state and one of only 13 awarded nationwide. The funding covers a two year period through August 2010. Activities are targeted to low income women of reproductive age living in Delaware County with special emphasis on pregnant women under 20, women of color, Hispanics and immigrants, women whose pregnancies were unintended, and women receiving Medicaid. The goal is to educate and empower women through health awareness. The program focuses on several key areas related to female health: nutrition, exercise, mental health, stress management, folic acid and safe relationships/sexual health. Promotional efforts include a comprehensive website, social networking sites, presentations at local schools and community organizations.
/2012/ The First Time Motherhood Grant ended August 31, 2010. //2012//

Staff represents the Secretary of Health on the PA Developmental Disabilities Council. The Council embraces a vision of a Commonwealth comprised of inclusive communities where all people with disabilities are valued and thrive. The Secretaries of Education, Public Welfare, Aging and Labor and Industry are also represented on this council and all agencies coordinate their efforts in assisting the Council in directional planning and oversight of the grants it issues. The Council supported 77 grant activities during calendar year 2009, ranging from grassroots demonstrations to statewide systems change grants. The Council also produces position and discussion papers, which are made available to the public on its website and through dissemination to stakeholders, as well as submission of critical issues to the Governor. Currently on the site are papers on Emergency Preparedness and Response, Cultural Competence, Voting, Inclusive Education, Employment, Criminal Justice, and Personal Care Homes. A new initiative during the current year will bring Council staff together with the Bureau of Family Health's Family Health Nursing Services Consultants, to connect the Consultants with community-based Council grantees that serve common populations. This will create the potential to connect individuals to services funded by Council grants, expand the Special Kids Network and System of Care provider network, and lay the groundwork for increased diversity in the Consultants' service delivery.
/2012/ The Council provided $2,697,336 in support of 60 grants during calendar year 2010. Topics under consideration for position papers include Community Imperative (Institutional Closing), Mental Health Parity, and Sexuality/Parenthood. //2012//

The Division of Newborn Screening and Genetics

The Division, which is comprised of the Newborn Screening, Newborn Hearing Screening and /2012/ Follow-up Program //2012// ***/2013/ Newborn Screening and Follow Up Program Point of Care //2013//*** and Genetic Services Sections, has undergone some key changes during the past year. The Newborn Screening Section added 22 conditions to the list for which follow-up is provided to total 28 metabolic and genetic conditions. The Bureau purchased and is proceeding with development and implementation of a state-of-the-art integrated newborn metabolic and hearing screening tracking and follow-up database from OZ Systems, which utilizes HL7 messaging. This system will increase efficiency and reduce cost of program operation by facilitating secure electronic case management and communications with providers. The Genetic Services Section has an on-going challenge to assure access to services statewide with a budget of $300,000. Historically, grants were awarded to providers based on the highly specialized services they provided. This translated into concentrating money in the Philadelphia and

Pittsburgh areas due to the existence of large medical research facilities. The field of genetics has expanded in recent years increasing the availability of services. To more equitably distribute funds, six ***/2013/ three //2013//*** grant opportunities are being made available. One grant will be offered in each of the six ***/2013/ three //2013//*** Pennsylvania districts.

/2012/ The Bureau purchased OZeSP for Newborn Hearing Screening and is preparing an Invitation For Bid (IFB) to identify an appropriate system for metabolic newborn screening. These systems must be capable of interfacing to increase efficiency and reduce cost of program operation by facilitating secure electronic case management and communications with providers. //2012//

Advances in the hearing screening program are enabling the Division to embrace the medical home concept for its clients. The Infant Hearing Education, Assessment, Reporting and Referral (IHEARR) Act (Act 89 of 2001) empowers the Department to administer a statewide comprehensive newborn hearing screening and follow-up program. The Division is interested in identifying the means to link infants to medical homes soon after discharge from their birth to enable the ideal primary care physicians to actively participate in direct care and follow-up. All of the state's 107 /2012/ 104 //2012// birthing hospitals report hearing screening results to the Division and refer failed screenings for follow-up tracking. Early Hearing Detection and Intervention (EHDI) Program data reveal that approximately 97.2% ***/2013/ 98.4% //2013//*** of all hospital births in 2008 ***/2013/ 2010 //2013//*** completed a hearing screening. The PA EHDI Program reviews monthly hospital hearing screening performance numbers and, through a contract with the PA Chapter of the American Academy of Pediatrics, offers identified hospitals technical assistance in an effort to improve hearing screening performance.
/2012/ The Department received a grant from HRSA for Universal newborn hearing screening and intervention to cover the costs of two training contracts with the PA Chapter of the American Academy of Pediatrics and Early Intervention Services. //2012//

State law currently mandates the screening and follow-up for six metabolic/genetic conditions: Congenital adrenal hyperplasia, Galactosemia, Hemoglobin diseases, Maple syrup urine disease, Phenylketonuria and Primary Congenital Hypothyroidism. The Newborn Child Testing Act (as amended by Act 36 of 2008, effective July 1, 2009), requires the Newborn Screening and Follow-Up Program to provide follow-up services related to case management, referrals, confirmatory testing, assessment and diagnosis for an additional 22 metabolic and genetic conditions to include Acylcarnitines, Amino Acids, Biotinidase and Cystic Fibrosis. All Pennsylvania hospitals offering maternity services now provide expanded screening.

***/2013/ About 25% of the birthing hospitals in PA now offer newborn screening for SCID. PA does not have a requirement that the testing laboratories report these results to the NSFP for follow up. Legislation has been introduced on March 19, 2012 for birthing providers to perform pulse oximetry screening for all newborns in PA. This legislation is pending. A preliminary survey of birthing hospitals in PA indicates that approximately 40% of these hospitals are currently performing pulse oximetry testing. //2013//***

The MCHSBG funds screening for all newborns and provides follow-up services to infants and children diagnosed with any of 28 tested metabolic conditions. Collaborative efforts are targeted to hospitals, metabolic disease treatment centers, other specialty centers, a host of medical and allied health providers, laboratories, and others. The Division presently offers early education for newborn screening prior to childbirth. The Division contracts for follow-up and case management with four Metabolic Disease Treatment Centers, ***/2013/ 4 cystic fibrosis treatment centers //2013//*** and 10 University and Community Centers for Sickle Cell Disease. ***/2013/ Contractual agreements with Geisinger Medical Center and the Lehigh Valley Health System beginning on July 1, 2012 will bring the total cystic fibrosis treatment centers to six. //2013//***

/2012/ The Division continues to contract with a medical consultant to provide assistance and guidance in the follow up process. Recently completed is the development of an algorithm for

each of the expanded screening conditions detailing follow-up workflow. Representatives of the Technical Advisory Board participated in the development of these documents and the Board approved them early this year. Representatives of the Board are multi-disciplinary and are comprised of medical experts and representatives of groups with knowledge and interest in newborn screening //2012//

***/2013/ The contracted medical consultant terminated services with the Department in May 2012. The Division is procured another medical consultant who started July, 2012. //2013//***

During the past year, the Division contracted with a medical consultant to provide assistance and guidance in the follow up process. One project reaching conclusion is the development of an algorithm for each of the expanded screening conditions detailing follow-up workflow. Representatives of the Technical Advisory Board participated in the development of these documents and the full Board will review and approve them prior to implementation. Representatives of the Board are multi-disciplinary and are comprised of medical experts and representatives of groups with knowledge and interest in newborn screening.

The NSFP administers a statewide metabolic pharmacy formula program that enables clients with PKU to obtain metabolic formula at a pharmacy of their designation. Financial coverage for the formula program has broadened for those clients receiving medical assistance ***/2013/ and who are also participating in the WIC program. //2013//***

The Division's genetic screening and counseling program ensures that eligible, low-income individuals and families seeking information about the occurrence, or risk of occurrence, of a genetic condition or birth defect are provided access to services. The Division issues grants to support comprehensive genetic screening centers and major metabolic screening and treatment centers. The hospital affiliated genetic screening centers' services include: explanation of the disorder(s) in question and associated problems; an examination of the family genetic history; research of the genetic condition; estimation of risk to family members and progeny; education on treatment and reproductive options; and referrals and follow-up for other services. The Genetics Program collaborates with seven comprehensive genetic screening centers and three major metabolic screening and treatment centers that function as part of newborn screening diagnosis treatment and case management services.
/2012/ The grants will end on June 30, 2011 and will be replaced by three new grants generated through an RFA for genetic services. //2012//

***/2013/ All ended grants will be replaced in SFY 2013-14 by three new grants generated through an RFA. Funding for these grants is a total of $400,000. //2013//***

/2012/ The Division's Genetics' Service program is in the process of issuing a RFA. The RFA is the foundation of building a genetics service program in Pennsylvania. The primary goal of the RFA is to promote the Health Resources and Services Administration's (HRSA) Genetic Services Branch program's concept of increasing knowledge of the genetic contribution to health and disease; facilitate the early identification of individuals with heritable conditions and integrate them into existing systems of care that are comprehensive, accessible, available, affordable, acceptable, population and community-based, culturally appropriate and family centered; as well as reduce duplication and fragmentation of services.

Additionally, the Genetics Services Program is exploring the development of a Birth Defect Surveillance System (BDSS). //2012//

***/2013/ The Genetics Services Program will begin the development of a Birth Defect Surveillance System (BDSS) through a grant funded from HRSA via the State System Development Initiative (SSDI) grant. //2013//***

The Division coordinates multidisciplinary team clinics across the state to serve children and

adults with special health care needs. The clinics provide professional expertise to improve systems of specialty care by coupling acute, chronic, and preventive medical care services with social and psycho-social care. Agreements are maintained with local medical and ancillary care providers to assure availability and accessibility to care other than in a tertiary center. The Commonwealth supports services for spina bifida, adult cystic fibrosis, Cooley's anemia, hemophilia and home services for children who are ventilator dependent. One-stop multidisciplinary team clinic visits afford patients a full gamut of necessary services to manage complex medical conditions. Services include specialized physician and surgical care, nutrition, case management, laboratory, radiology, pharmacology, speech therapy, physical therapy, occupational therapy, orthotic care, dental care and health education. These specialty services are delivered in a comprehensive, multidisciplinary manner using a team approach. The Division seeks to integrate children with metabolic and genetic conditions into medical homes that provide specialty care to adults and children.

The Division administers the Sickle Cell Disease (SCD) Program which provides medical and psycho-social services to children and adults statewide. Persons diagnosed with sickle cell disease and their families may receive care and services. Grantees include: four university-based hospital grantees that provide comprehensive medical care and psycho-social services to children and adults via a multidisciplinary team approach, and six community-based grantees that provide outreach, education and psycho-social services to patients and their families as well as the community at large. These providers employ the Medical Home concept to coordinate care and services to optimize patient outcomes. They work collaboratively to create a statewide presence and act as consultants to each other and to other health care professionals regarding the care and treatment of persons with Sickle Cell disease.
/2012/ The Governor's proposed budget for State Fiscal Year 2011-12 recommends consolidation of state funds that support services for spina bifida, adult cystic fibrosis, Cooley's anemia, hemophilia, sickle cell disease, and home services for children who are ventilator dependent. This recommendation would collapse four appropriations into one, and reduce that appropriation by 45%. //2012//

***/2013/ The Governor's proposal for consolidation of state funds for these special conditions was not approved in the budget. Each condition retained its unique line funding but received funding cuts. //2013//***

In 2009, the Division was awarded a grant from the National Center on Birth Defects and Developmental Disabilities of the Centers for Disease Control and Prevention for a Population-based Surveillance for Hemoglobinopathies Project (RuSH). The proposed work includes formation of a consortium to facilitate outreach across the state to identify, assess and analyze data on patients with hemoglobinopathies. The Division received $534,056 per year for two years. The RuSH grant is a multi-phase project in which six states work together with CDC to assess availability of data, develop new data sources, and design a data collection and reporting surveillance system that will ultimately become a national registry for patients with sickle cell disease and Thalassemia. The work done through this grant will be the cornerstone for Pennsylvania to develop its own sickle cell registry, and be part of an integrated electronic information database that can be accessed by medical providers resulting in improved care to patients.

***/2013/ Funding for the RuSH project ended May 11, 2012. The goal of designing a data collection and reporting surveillance system was achieved; however efforts to build a national registry are on hold pending additional CDC funding. //2013//***

The Division of Women, Infants and Children (WIC)

The Division of WIC administers the Special Supplemental Nutrition Program for Women, Infants and Children in Pennsylvania. The Program provides supplemental nutritious foods, nutrition assessment, counseling and education, overweight and obesity prevention counseling,

breastfeeding promotion and support, prenatal and pediatric health care referrals, immunization screening and drug and alcohol abuse referrals to women who are either pregnant or up to one year postpartum, infants and children up to the age of five. Although the WIC Program is funded by the USDA, it serves the Title V eligible population with income eligibility capped at 185% of the federal poverty level.

The WIC program provides services in all 67 Pennsylvania counties through 24 private non-profit or governmental WIC Local Agencies who provide services in a defined geographic area. These local agencies operate 334 /2012/ 306 //2012// ***/2013/ 280 //2013//*** WIC clinics in strategic locations throughout the state. In order to determine program eligibility these WIC clinics conduct a medical and dietary evaluation to determine nutritional risk, evaluate income sources to determine income eligibility and conduct in depth interviews with participants to determine what referrals would be appropriate.

The economic recession increased the demand for services as WIC saw program participation grow to 267,301 in November 2009. This was a 2.7% increase from 260,107 participants a year earlier. In 2009 the WIC program implemented the most sweeping changes to its food packages provided to WIC participants since the inception of the program. These changes include the introduction of fruits and vegetables, infant foods and whole grains to the program offerings. The program has undergone major changes in its nutrition service delivery techniques through the implementation of the Value Enhanced Nutrition Assessment (VENA) and guided goal setting. /2012/ WIC participation peaked in November 2009 at 267,301, declined slightly through the spring and summer months and started picking up again in August and September 2010, which saw an average monthly caseload of 263,635. Participation in November 2010 was 261,142, a difference of 2.3%. The main initiative undertaken by WIC in 2010 was planning activities related to Electronic Benefits Transfer (EBT) of WIC benefits. PA WIC received funding to conduct planning activities and determined that a smartcard solution would be the most cost-effective and logical solution to employ. A funding request has been submitted to USDA for implementation of this technology, with a pilot scheduled to start in 2013. //2012// ***/2013/ Monthly participation is 252,555. //2013//***

The USDA Peer Counselor Program grant was increased which allowed PA WIC to expand this service. Four more agencies submitted proposals and have received initial training to implement the Peer Counseling Program and currently existing programs proposed to expand the number and/or hours of their peer counselors. There are now a total of ten local agencies with Peer Counselor Programs. Additionally, in efforts to increase the duration of breastfeeding, the WIC Program increased the amount of funding for breast pumps by 38% from $454,400 in federal fiscal year 2009 to $628,289 in federal fiscal year 2010.
/2012/ With the additional peer counselor funds, the number of peer counselors (PC) has increased from 24 to 62. Some are part time, some full time. The 62 PCs provide 1,100 of hours of direct breastfeeding counseling services to WIC participants each week. //2012// ***/2013/ The program received a bonus award for increasing the breastfeeding rates overall from 29% to 50%. The award of $822,739 was presented to the program on November 17, 2011. The dollars will be provided to the local agencies to enhance their breastfeeding initiatives as well as work with community hospitals to increase the number of peer support groups in certain geographic areas. //2013//***

The Division of WIC has taken an active role in the fight against food insecurity. The Division Director participated in a meeting with the Governor's Office and US Representative Robert Brady's Office to develop a strategy to combat hunger in the 1st Congressional District which in a recent survey ranked second in the nation in food insecurity.

The Division of Bureau Operations

The Division of Bureau Operations is a non-programmatic Division charged with managing and directing the Bureau of Family Health operations and administrative functions. This includes

budgeting, procurement, information technology, equipment and human resources. This also includes the Bureau of Family Health's training efforts related to confidentiality, privacy and security requirements imposed by state and federal law, such as the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) passed as part of the American Recovery and Reinvestment Act of 2009. The Division of Bureau Operations also conducted training on the newly implemented policies and procedures regarding the Commonwealth's Right to Know Law (RTKL) which was enacted on January 1, 2009. This Division also assists in the reproduction and dissemination of the MCHSBG Annual Report and Application.

***/2013/ Starting July 2012, the Health and Human Services Call Center (HHSCC) will be under the Division of Bureau Operations. The Center will take calls relative to Lead, Healthy Baby, overflow calls for Healthy Kids, and the Office of Long Term Living. The HHSCC will provide information, referral and outreach services for programs serving MCH and CSHCN. The purpose of the Call Center is to be a cost-effective, "one stop" source for health and human service information for the state's citizens. The HHSCC will use the Language Line services available to the Commonwealth, offering bilingual services to any citizen in need. //2013//***

Rehabilitative Services for Blind and Disabled Individuals
Although the Department of Health is not the agency responsible for the provision of rehabilitation services for blind and disabled children under age 16, the Department of Labor and Industry provides blind and visual services for children throughout the Commonwealth via professional staff in District Offices located in Altoona, Erie, Philadelphia, Harrisburg, Pittsburgh, and Wilkes Barre. Services include: counseling; advocacy for educational services; transition services; guidance and counseling for children and their families; community orientation and mobility instruction; children's summer programs; rehabilitation teaching; adaptive equipment; and, low vision services. Financial and visual eligibility is established before goods and services are purchased for the child.

***An attachment is included in this section. IIIB - Agency Capacity***

## C. Organizational Structure

Edward G. Rendell was inaugurated as the Commonwealth of Pennsylvania's 45th Governor on January 21, 2003. The Governor serves as Chief Executive of the nation's 6th most populous state. The Governor's Cabinet is comprised of senior staff, Agency Heads and Deputy Secretaries. Each Secretary is responsible for the oversight of his or her agency. An equally important responsibility of all Cabinet members is advising the Governor on subjects related to their respective agencies. In 2007, Edward G. Rendell was elected another four year term. Please see attached file for Department of Health Organization Chart. On September 26, 2008, the Governor named Everette James, J.D., M.B.A., to serve as Secretary for the Department of Health. In this position the Secretary serves as the primary public health advocate and spokesman for Pennsylvania. As Pennsylvania's top health regulator, Secretary James is responsible for carrying out the Health Department's mission. Prior to his appointment as Secretary of Health, he served as a senior advisor to the Governor. He advised the Governor on health care and pension issues affecting the Commonwealth. James served as the Governor's senior staff liaison to the Departments of Health, Welfare, Insurance and Aging. He also served as a Trustee of the Public Employee Benefits Trust Fund and was the Governor's designee to the Boards of the Ben Franklin Technology Development Authority and the Public School Employees' Retirement System.

The mission of the Pennsylvania Department of Health is to: 1) promote healthy lifestyles; 2) prevent injury and disease; 3) ensure the safe delivery of quality health care services for all Pennsylvanians; and 4) eliminate health disparities. This mission is reflected in the Department's core functions identified as assessing health needs, developing resources, ensuring access to

health care, promoting health and disease prevention, ensuring quality, and providing leadership in the area of health planning and policy development. The core functions of the DOH are carried out by four Deputy Secretaries; 1) Health Planning and Assessment; 2) Quality Assurance; 3) Health Promotion and Disease Prevention; and 4) Administration. Bureaus housed within these Offices that play a significant role in program administration and service delivery to the maternal and child population are highlighted under its corresponding Office.

Many of Pennsylvania's public health personnel are concentrated in the 10 municipal and county health departments. In Pennsylvania, public health workers are employed by the State and county/municipal health departments. In relation to its population, Pennsylvania has the lowest number of public health personnel of any State, with only 37 professionals per 100,000 residents, which is less than one-third of the national average. The most significant shortage is public health nurses, who account for about 15 percent of the public health work force.

The Department of Health oversees health services administered to residents of Pennsylvania's 67 counties through a system of 6 community health districts, 60 State Health Centers and 10 county and municipal health departments though the Bureau of Community Health Systems, represented in the MCH needs analysis. The six community health districts have the following geographic designations: Northwest, North-central, Northeast, Southwest, South-central, and Southeast.

The Deputate of Health Promotion and Disease Prevention has responsibility for developing and implementing a wide variety of education, preventative, and treatment programs including, but not limited to the areas of communicable diseases; family health, including infant nutrition programs; cancer; HIV/AIDS; and tobacco, drug, and alcohol abuse. The Bureau of Family Health is responsible for the administration of Title V programs.

/2012/ Tom Corbett was inaugurated as the Commonwealth of Pennsylvania's 46th Governor on January 18, 2011. The Governor serves as Chief Executive of the nation's 6th most populous state. The Governor's Cabinet is comprised of senior staff, Agency Heads and Deputy Secretaries. Each Secretary is responsible for the oversight of his or her agency. An equally important responsibility of all Cabinet members is advising the Governor on subjects related to their respective agencies. Please see attached file for Department of Health Organization Chart. The Governor announced Eli N. Avila MD, JD, MPH, FCLM as his nominee for Secretary of the Department of Health, a position Dr. Avila undertook on January 18, 2011. In this position the Secretary serves as the primary public health advocate and spokesman for Pennsylvania.

As Pennsylvania's top health regulator, Dr. Avila is responsible for carrying out the Health Department's mission to promote healthy lifestyles, prevent injury and disease and to assure the safe delivery of quality health care for all Pennsylvania citizens. Dr. Avila is a practicing physician, attorney and public health executive. Before joining the the commonwealth, he worked as Chief Deputy Commissioner of Health Services for Suffolk County, NY -- the seventh largest county in the United States, managing an annual budget of more than $400 million and overseeing a staff of nearly 1,500 employees. Dr. Avila recently practiced law in New York City for an environmental biotechnology company and practiced administrative/clinical medicine as the Senior Examining Occupational Medicine Physician for the Department of Health and Human Services' Federal Occupational Health Service in the Capital Region of New York.

The Deputate of Health Promotion and Disease Prevention has responsibility for developing and implementing a wide variety of education, preventative, and treatment programs including, but not limited to the areas of communicable diseases; family health, including infant nutrition programs; cancer; HIV/AIDS The Bureau of Family Health is responsible for the administration of Title V programs. An attachment is included in this section. //2012//

***An attachment is included in this section. IIIC - Organizational Structure***

## D. Other MCH Capacity

The Bureau of Family Health, through its Divisions of Child and Adult Health Services (CAHS), Community Systems Development and Outreach (CSDO), Newborn Screening and Genetics (NSG), and Special Supplemental Nutrition Program for Women Infants and Children (WIC) exercises its capacity to promote and protect the health of all mothers and children, including children with special health care needs (CSHCN), through a variety of services. The following are the Title V funded positions.

PA Department of Health -- Departmental Title V Funded Staff for Calendar Year 2010.
Program - Number of Funded Personnel - Location
Bureau of Family Health

BFH Bureau Office - 2 - Harrisburg, PA
/2012/ BFH Bureau Office - 3 - Harrisburg, PA //2012//
Bureau Operations - 4 - Harrisburg, PA
/2012/ Bureau Operations - 7 - Harrisburg, PA //2012//
***/2013/ Bureau Operations -- 8 -- Harrisburg, PA //2013//***
Child and Adult Health Services - 16 - Harrisburg, PA
***/2013/ Child and Adult Health Services -- 17 -- Harrisburg, PA //2013//***
Community Systems Development & Outreach - 12 - Harrisburg, PA
/2012/ Community Systems Development & Outreach - 15 - Harrisburg, PA //2012//
Newborn Screening and Genetics - 20 - Harrisburg, PA
/2012/ Newborn Screening and Genetics - 21 - Harrisburg, PA //2012//
Other DOH Offices
Community Health Systems -School Health - 2 - Harrisburg, PA
Community Health Systems-MCH & SHCN Nurses - 12 - Statewide
Bureau of Laboratories - 2 - Lionville, PA
Bureau of Information Technology - 1 - Harrisburg, PA
Office of Legal Counsel - 1 - Harrisburg, PA
Bureau of Health Risk Reduction - 1 - Harrisburg, PA
***/2013/ Bureau of Health Risk Reduction - 0 - Harrisburg, PA //2013//***
/2012/ Policy Office -1- Harrisburg, PA //2012//
TOTAL - 73
/2012/ TOTAL - 82 //2012//
***/2013/ TOTAL - 83 //2013//***

Bureau of Family Health -- Director: Melita Jordan, CNM, MSN, APRN C
Ms. Jordan has served in her current capacity as Director of the Bureau of Family Health since September 2004. She has more than two decades of experience in the field of maternal child health. Previously she served as Director of Women's Services and Director of Nurse-Midwifery Services at Mercy Hospital of Philadelphia. From 1988 to 1990, she served as Chair of the Mayor's Commission for Women's Health Task Force for the City of Philadelphia. She graduated from Seton Hall University with a B.S. in Nursing and received her Master of Nursing Science from the University of Medicine and Dentistry of New Jersey. She serves as an Adjunct Faculty member at Drexel University School of Public Health Doctorial and Executive MPH Program as well as the MCH Director for the Commonwealth.

/2012/ Ms. Melia Belonus assumed the role of bureau director in the Bureau of Family Health, Pennsylvania Department of Health in June 2011. She is responsible for the planning, organization and administration of statewide programs for maternal and child health services, to include the supplemental food program for WIC. The budget for this bureau exceeds $300 million dollars. She acts as the State Title V Maternal and Child Health Services Director at the federal level, and establishes strategic program priorities and management objectives within the bureau.

Ms. Belonus' career includes leadership roles in the Governor's Policy Office where she was instrumental in major issue development and decision-making for the Governor and Senior Staff, for health and human service programs. At the Bureau of Management Consulting, she led a team of internal management consultants serving all agencies under the Governor's jurisdiction. As Deputy Director for the Office of Strategic Services, Ms. Belonus led management staff in a wide array of complex tasks that served all agencies under the Governor's jurisdiction to include process improvements and organizational development. At the Pennsylvania Department of Health, Ms. Belonus served as acting bureau director in the Bureau of Community Program Licensure and Certification. In this role, she was responsible for the state licensure and federal certification of community providers.

Ms. Belonus is a recognized leader known for her expertise in Pennsylvania Government policy development, research and fiscal management. Her executive management track record encompasses over 20 years of experience in the requisite strategic vision to achieve business goals. Ms. Belonus offers executive acumen, team building and organizational development methods. Ms. Belonus has constructed many responsive organizations that consistently deliver results by aligning business goals with substantial improvement to service delivery, standardization and business/systems performance. She has effectively managed staff in the development and implementation of operational improvements for all agencies under the Governor's jurisdiction within the Commonwealth.

Ms. Belonus holds a Master of Public Administration degree from the Pennsylvania State University. //2012//

Bureau of Family Health -- Director of the Division of Bureau Operations: Robin Cohick
Ms. Cohick assumed the responsibilities of Director of the Division of Bureau Operations on July 7, 2008. Before coming to the Bureau of Family Health, Ms. Cohick was the Chief Grants and Fiscal Administrator in the Bureau of Health Statistics and Research. She has twenty-five years of service in the Department of Health working in several other Bureaus.
/2012/ Ms. Cohick retired from the Bureau in February 2011. Roxann Arbegast-Boes assumed the role of Director of the Division of Bureau Operations in June 2011. Ms. Arbegast-Boes's began her career with the PA Department of Health (DOH) in August 1992. Prior to her new role as Director, she held various administrative positions, served as a Budget Analyst then was promoted to Executive Assistant for the Deputy Secretary for Quality Assurance, PA Department of Health in 2007. She was awarded the PA Department of Health Excellence Award in 2001.

Ms. Arbegast-Boes holds a Bachlor's degree in Psychology from the Unitversity of Wyoming. //2012//

Bureau of Family Health-Director of the Division of Child and Adult Health Services: Carolyn Cass, Ph.D.
Ms. Cass has worked in the field of public health since 1997. Prior to that, she worked in the field of behavioral health for over 15 years, primarily providing drug and alcohol treatment services for adolescents and individuals in the state hospital system. Ms. Cass has served as adjunct faculty at West Chester University since 1994 and has served on the faculty at Temple University as well.

Bureau of Family Health-Director of the Division of Community Systems Development and Outreach: Michelle Connors
Ms. Connors has served in the field of Public Health for over 20 years. She came to the Department in 1989 and has served as the state's Title V Children with Special Health Care Needs Director since 2002. Ms. Connors holds a Bachelor's Degree from Pennsylvania State University and her Division manages a variety of programs that focus on children with disabilities.

Bureau of Family Health-Director of the Division of Newborn Screening and Genetics: William Cramer

Mr. Cramer has worked in the public health field for the past 10 years. He assumed the position of Director of Newborn Screening and Genetics on January 1, 2010. Prior to his appointment, he worked as the Director of Healthcare Associated Infection (HAI) where he was responsible for the development and implementation of statewide HAI reporting in the Department's Office of Quality Assurance. He has also held the position of Health Facility Quality Examiner (HFQE) as well as Complaint and Investigation Supervisor in Quality Assurance's Division of Nursing Care Facilities. During his first 10 years of state employment, he worked in the correctional system as a Drug and Alcohol Treatment Specialist and Supervisor. He has a Master's of Education from Penn State University and a Bachelor's from Indiana University of PA.

Bureau of Family Health-Director of the Division of WIC: Gregory Landis
Mr. Landis has been with the WIC Program since July 1988, first as Chief of the Grants and Retail Store Management Section and in May 2007 he assumed the role of Director.
/2012/ Bureau of Family Health Director of the Division of WIC: Shirley H. Sword, MS, RD, LDN (Acting) Ms. Sword began her career with the WIC Program in 1994 as a lactation specialist and then Nutrition Education Coordinator for Family Health Council of Central PA, a local agency. In 2000, Ms. Sword joined the Department of Health as a Public Health Nutrition Consultant and was promoted in 2003 to Chief, Nutrition Services Section. She was a member of the Board of Directors for the National WIC Association (NWA) from 2003- 2005, participated as a member of the joint USDA/NWA workgroup that developed the Value Enhanced Nutrition Assessment initiative for USDA, was Project Director for two USDA Special Project Grants, and has most recently been involved in the research and planning activities for moving PA WIC towards EBT. Ms. Sword was named Acting Director in January 2010 upon the retirement of Mr. Greg Landis. //2012//

***/2013/ Mary King-Maxey was named as the Director for the Division of WIC on December 19, 2011. Ms. King-Maxey was with WIC for five years from 1996-2001, she then administered the Healthy Baby Helpline activities from 2001-2007, most recently she was the Manager for the Bureau's Newborn Hearing Screening Program from 2007-2011. //2013//***

Bureau of Community Health Systems, Acting Director: Jeffrey A. Blystone
Mr. Blystone is the Acting Director of the Bureau of Community Health Systems. He is responsible for directing the provision of numerous public health services that includes health promotion and education, immunization, and the monitoring, tracking and control of communicable diseases to the citizens of the Commonwealth. Additionally, he oversees the coordination of similar programs within six (6) county and four (4) municipal health departments and collaborates with other state and community agencies, professional groups, and community organizations.

Bureau of Community Health Systems- Acting Director of the Division of School Health: Beth Bahn
Ms. Bahn is the Acting Director, Division of School Health. Ms. Bahn has been with the Division as a State School Health Consultant since 2005. Her prior experience includes: 12 years with the Red Lion Area School District as a Certified School Nurse, the last 3 years as a Certified Registered Nurse Practitioner; and 12 years as a Charge Nurse with York Hospital. She is a Founding member of Pennsylvania Association of School Nurses and Practitioners and has served 12 years on their Board of Directors.

Bureau of Health Promotion and Risk Reduction, Director: Leslie Best
Ms. Best is the Director of the Bureau of Health Promotion and Risk Reduction overseeing statewide planning and implementation of health promotion and disease prevention programs. The BHPRR addresses heart disease and stroke, cancer, arthritis, diabetes, tobacco prevention and cessation, oral health, physical activity, and health education services. Employees in this Bureau have Title V responsibilities include Stewart Williams, Violence & Injury Prevention Program Administrator. Mr. Williams is responsible for the Childhood Injury Prevention Program

(CIPP). Howard Tolchinsky, DMD, State Public Health Dentist, is responsible for the Oral Health Program. The mission of the Oral Health Program is to promote good oral health as an integral part of the well-being of all Pennsylvania citizens, reinforcing the concept that you cannot be truly healthy without good oral health. The Division of Tobacco Prevention and Control is currently recruiting for a program administrator to coordinate youth prevention programs with regional contractors.

Bureau of Epidemiology -- Ronald Tringali, PhD, RN
The Bureau of Family Health's designated Epidemiologist is Ronald Tringali, PhD, RN. Prior to serving in this position, Dr. Tringali served as Section Chief for the Health Assessment Section of the Division of Environmental Epidemiology and as Epidemiologist for the statewide Breast and Cervical Cancer Program. Dr. Tringali was also the Research Clinical Nurse Specialist for the Center for Nursing Research at the Penn State Milton S. Hershey medical Center. Dr. Tringali has held an adjunct appointment in the School of Nursing at the University of Pittsburgh.

Chief Counsel's Office - - Rachel Hammond, Esq.
The Bureau of Family Health's designated Attorney is Rachael Hammond. She attended the Pennsylvania State University and the Dickinson School of Law. Ms Hammond provides legal counsel to the Bureau of Family Health programs (except WIC operations).
/2012/Ms. Hammond resigned from PA Department of Health on June 10, 2011. The Bureau of Family Health's designated attorneys are Audrey Miner, Esq., legal council for the Divisions of Community Systems Development and Outreach and Child and Adult Health Services, and Mike Siget, Esq., legal council for the Divisions of Women Infants and Children, and Newborn Screening/Hearing and Genetics. //2012//

***/2013/ The Bureau of Family Health's designated attorneys are Puja Khare, Esq., legal counsel for the Division of Women, Infants and Children, and Douglas Snyder, Esq., legal counsel for the Divisions of Newborn Screening, Hearing and Genetics, Community Systems Development and Outreach and Child and Adult Health Services. //2013//***

Bureau of Community Health Systems
The Division of School Health in the Bureau of Community Health Systems monitors and evaluates school entities' (500 school districts, 125+ charter schools, 10 comprehensive vo-tech schools, and 29 intermediate units) compliance with State laws, regulations, and policies; provides consultation and technical assistance to schools to support and improve health programs and services; develops policy, procedures, guidelines and adopts records and report forms to support and facilitate the efficient operation, administration and evaluation of the school health program; and fosters state and local cooperation and coordination of programs and services. These activities are facilitated through the efforts of two full-time State School Health Consultants who are funded by the Bureau of Family Health, led by the Division Chief. /2012/ The State School Health Consultants provide consultation and technical assistance to over 2,000 certified school nurses in 500 school districts, 11 comprehensive vocational schools, over 150 charter schools and numerous non-public schools regarding planning, development and implementation of school health programs and school nursing services. //2012//

## E. State Agency Coordination

The Bureau of Family Health has significant collaborative relationships and coordinated efforts with other state agencies (described below), local health departments, the MCH Leadership Program at the University of Pittsburgh, other universities such as Drexel and University of Pennsylvania, and professional associations such as the PA-American Academy of Pediatrics, the Hospital and Healthsystem Association of Pennsylvania (HAP) and family leadership and support programs such as the Parent Education and Advocacy Learning Center (PEAL Center).

Coordination with Multi-State Agencies

Through the Memorandum of Understanding for a Shared Agenda for Youth and Young Adults with Disabilities, members of the Pennsylvania Transition State Leadership Team (the Departments of Health, Labor and Industry, Public Welfare and Education), work together in supporting youth/young adults with disabilities transitioning into adult life. These four agencies, along with families, youth/young adults with special health care needs, and community partners address issues of youth as they transition out of secondary education. The group's work focuses on sharing data, building cost effective and natural support systems for youth, supporting statewide and comprehensive systems change, educating families and youth about transition, identifying gaps and opportunities in services and supports from across systems perspective. Two major accomplishments of the group are the annual statewide Transition Conference with scholarships for families and youth/young adults, and the distribution of the Secondary Transition Packet to all 14 year old youth/young adults in Pennsylvania's schools. The collecting of data ensures that quality services are delivered. By sharing data between agencies we can effectively improve the quality of services available to families of children with special health care needs without costly duplication.

Pennsylvania's Health and Human Services Call Center (HHSCC) is the result of a collaborative effort with Departments of Aging, Public Welfare and the Insurance Department. Through this partnership, each agency financially supports their respective helplines, but collaboratively works to support the Call Center as a "one call" source of information for Pennsylvania citizens. An individual, for instance, can be provided with information about breastfeeding for their infant, lead poisoning prevention for their preschooler, medical insurance during an economic downturn, learn about recreational opportunities for a child with special health care needs and find services for their aging mother through a single call. Agency line managers meet on a monthly basis with HHSCC staff to discuss operational needs, issues of mutual benefit for callers, and expansion of the Call Center. Outreach activities are shared by agency representatives and HHSCC staff. Informational materials from various helplines are provided to outreach participants for distribution to the public. This collaborative effort has strengthened the work of the agencies through networking opportunities that continue to create more responsive systems for all citizens. /2012/ The Call Center also operates as a conduit for questions related to newborn screening letters and the metabolic formula program as well as avenue to obtain newborn screening results after normal business hours. //2012//

***/2013/ The contract with Policy Studies, Inc. will terminate June 30, 2012. The DOH is building a contact center within the Commonwealth system that will transparently transition calls from the contractor to Department staff. A goal of the effort is to respond to all calls continuously on July 2, 2012 and provide access to the information and resources of the helplines equal to that occurring under the contract with Policy Studies, Inc. //2013//***

/2012/ Through the Department of General Services, the Bureau of Family Health contracts with Policy Studies, Inc., vendor for Pennsylvania's Health and Human Services Call Center (HHSCC) to provide information, referral and outreach services for bureau programs serving MCH and CSHCN. This contract is part of a collaborative effort with the Departments of Aging, Public Welfare, and Insurance. As Project Officer, the Department of General Services works with the agencies to monitor the contract. Agency line managers coordinate operations and monitor performance for quality assurance. The purpose of the HHSCC is to be a cost-effective, "one stop" source for health and human service information for the state's citizens. In one toll-free call to any help line, an individual might be provided with information on breastfeeding an infant, lead poisoning prevention for a preschooler, medical insurance for the family, recreational opportunities for a child with special health care needs, and long-term living options for an aging parent. The HHSCC has five bilingual employees, offering the option of English, Russian or Spanish speaking representatives. Also, rather than four agencies contracting for operational costs, such as language line services, the HHSCC absorbs this expense under one, centralized contract. In a complex system of care, Pennsylvania's consolidation of related help lines has provided the state's citizens with easier access to comprehensive information on a wide range of

health and human services and programs and it has strengthened the work of the agencies. //2012//

***/2013/ Beginning in July 2012, the HHSCC will be under the auspice of the Bureau of Family Health, Division of Bureau Operations. The Call Center will take calls relative to Lead, Healthy Baby, overflow calls for Healthy Kids, and the Office of Long Term Living. The Call Center (HHSCC) will provide information, referral and outreach services for bureau programs serving MCH and CSHCN. The purpose of the Call Center is to be a cost-effective, "one stop" source for health and human service information for the state's citizens. In one toll-free call to any help line, an individual might be provided with information on breastfeeding an infant, lead poisoning prevention for a preschooler, medical insurance for the family, recreational opportunities for a child with special health care needs, and long-term living options for an aging parent. The Call Center will use the Language Line services available to the Commonwealth, offering bilingual services to any citizen in need. //2013//***

Senate Bill 246, Pennsylvania's Clean Indoor Air Act (CIAA), passed on June 10, 2008 and became effective on September 11, 2008. This legislation named the Department of Health (DOH) the lead agency for implementation of the CIAA. Eliminating exposure to secondhand smoke (SHS) and promoting cessation are two evidence-based strategies cited by the U.S. Centers for Disease Control and Prevention (CDC) that can contribute to a reduction in disease, disability and death related to tobacco use and SHS exposure. Many reports and studies consistently document reductions in tobacco use following the implementation of smoke-free laws and policies.

The DOH partners with the following agencies to coordinate implementation and enforcement of the CIAA and to create an efficient application and reporting process for DOH to review exception requests for drinking establishments, cigar bars and tobacco shops:
•Department of Aging
•Department of Agriculture
•Department of General Services
•Department of Public Welfare
•Department of Revenue
•Office of Administration, Bureau of Labor Relations
•Office of General Counsel
•Pennsylvania Gaming Control Board
•Pennsylvania State Police
•Pennsylvania Liquor Control Board
•Bureau of Liquor Code Enforcement
•/2012/ Insurance Department //2012//

The DOH eight regional Primary Contractors are responsible for providing tobacco use prevention and cessation services throughout the Commonwealth, including services relating to the implementation of the CIAA. All Primary Contractors have received training in the implementation of the CIAA and in the provision of technical assistance to affected establishments, and are assisting the DOH in the verification of exception requests. The Departments of Health and Public Welfare contract with four regional Family Health Councils to support family planning services at approximately 246 local clinics throughout Pennsylvania. Utilizing funding from four different sources, these State agencies pay for services through one integrated reimbursement system utilizing a common fee schedule. Funding sources include the Department of Health's Title V funding for teens 17 years of age and under, the Department of Public Welfare's Title XIX and Title XX funding, and State funding for breast cancer screening and women's medical services. The United States Department of Health and Human Services Title X funding is provided directly to the Councils.

Bureau of Family Health staff, along with staff from the Department of Public Welfare's Office of

Medical Assistance Programs and the Insurance Department's Children's Health Insurance Program (CHIP), participate in bi-monthly Reaching Out Partnership meetings to identify and coordinate common interests relating to services for individuals receiving Title V, Title XIX, and Title XXI services. This interagency work group coordinates activities to achieve shared outcomes for these populations. These activities include refining the definition and eligibility criteria of populations served, sharing data, linking provided services, and sharing of respective agency needs assessment and satisfaction survey data. This partnership has expanded beyond the three original Agencies to include all partner Agencies under the Health and Human Services Call Center.

The Interagency Committee to Coordinate Services Provided to Individuals with Disabilities, The IDEA Memorandum of Understanding, was established by the Governor's Executive Order in 1998. This MOU is the underpinning of a collaborative work effort among the Departments of Labor and Industry Office of Vocational Rehabilitation, Public Welfare, Education, and Health to improve coordination of service. The PA Community on Transition, State Leadership Team carries out the intent of the MOU and works together in supporting the post-school outcomes for youth and young adults with disabilities transitioning into adult life. The mission of the Leadership Team is to build and support sustainable community partnerships that create opportunities for youth and young adults with disabilities to transition smoothly from secondary education to the post-secondary outcomes of competitive employment.

/2012/The Bureau of Drug and Alcohol Programs (BDAP)
BDAP collaborates with Bureau of Family Health (BFH), within the Pennsylvania Department of Health and various other state departments through the through the Fetal Alcohol Spectrum Disorders (FASD) State Task Force. This Task Force is comprised of parents whose children are affected by FASD, as well as a wide representation of professionals from the public and private sectors. Partnerships with the BFH and these various other entities are necessary in addressing FASD to effectively intervene with prevention, intervention and treatment because the implications of this health issue crosses a wide range of service systems and across the lifespan. The Task Force finalized an FASD State Action Plan approved by the Department of Health in August 2008.

BDAP collaborates with BFH and other state agencies on the Pregnancy Risk Assessment Monitoring System (PRAMS) initiative. PRAMS is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. //2012//

Coordination with the Department of Public Welfare

The Bureau of Family Health works in partnership with the Department of Public Welfare (DPW) in a statewide effort aimed at encouraging pregnant women and new moms to sign up for text4baby. Text4baby, an innovative educational program of the National Healthy Mothers, Healthy Babies Coalition, is a free mobile text messaging service that provides pregnant women and new moms with health information to help them care for and give their babies the best possible start in life. Women who sign up for the service receive three text messages each week. The messages are timed to their due date or the baby's date of birth and focus on a variety of topics critical to maternal and child health: prenatal care, emotional well being, labor and delivery, smoking cessation, breastfeeding, mental health, immunizations and safe sleep. The messages continue through the baby's first birthday.
/2012/ The Bureau of Family Health continues to partner with the Department of Public Welfare (DPW) to promote Text4Baby. Through this collaboration, Text4Baby reaches its target population via public health programs where expectant mothers receive care plus the health professionals who come into contact with pregnant women, new mothers and their babies. A wide range of promotional activities have taken place since the program's inception in 2010. As a result of the promotional strategies that drive end users to sign up for the program, only seven

other states have higher enrollment in Text4Baby than PA. //2012//.

***/2013/ The Bureau of Family Health continues to work collaboratively with the Department of Public Welfare to promote text4baby throughout the Commonwealth. Some promotional activities include: information in mailings through Maternity Case Managers, use of listservs and distribution of materials such as posters and tear off sheet to all County Assistance Offices. Through this collaboration, more than 14,000 users have enrolled in text4baby in Pennsylvania since its February 2010 launch. //2013//***

The Lead Poisoning Data Match project is a collaboration between the Division of Child and Adult Health Services (DCAHS) and DPW's Office of Medical Assistance Programs. The goal is to exchange information between agencies to identify children receiving Medical Assistance (MA) who have been tested for lead. The project operates per a Letter of Agreement signed by both Departments on July 24, 2009, paving the way for the transfer of data files on a quarterly basis. In addition to helping identify MA children tested for lead, the datasets and output files received from DPW are also used to update the Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS) with the MA Identification Numbers of children who have received lead tests. This creates a more accurate set of data regarding lead testing for MA children.

Another lead poisoning prevention collaboration between DCAHS and DPW is the dissemination of information DPW's Managed Care Hotline contractor. DOH Lead Section regularly meet with the DPW contractors and staff to present information about the operation of the Lead Poisoning Prevention and Control Program, explain what the program does, answer questions, and offer resources for further information. This collaboration ensures that the Case Management Guidelines are available to the managed care plans and supports use of, and adherence to, the Guidelines.

In 2009, staff from the DCAHS met with key staff from DPW's Office of Children, Youth and Families (OCYF) and with staff from the local Children and Youth offices in Philadelphia and Erie to develop a strategic plan to implement the Healthy Homes Foster Care project (funded by HUD). Grant objectives and the parameters of the proposed grant agreements with the cities of Philadelphia and Erie were agreed upon and an action plan was developed. The OCYF representatives agreed to support the Healthy Homes project. This plan resulted in the DCAHS receiving American Recovery and Reinvestment Act (ARR) funding to support this collaborative project. The OCYF offices provide ongoing referrals to the cities' Healthy Homes offices.

The Division of Community Systems Development and Outreach (CSDO) staff supported by the US Environmental Protection Agency (EPA) (State Lead Program) has a contractual relationship with the Lead Abatement Training Center in Danville, PA where Lead Contractor training services are provided. Through a Memorandum of Understanding, the DPW provides physical plant oversight; the Department of Labor and Industry provides accreditation for trainers and certification for individuals successfully completing training. The State Lead Program provides outreach opportunities in collaboration with the Health and Human Services Call Center for all programs within the CSDO, as well as the Lead Poisoning Prevention and Control Section located within the DCAHS. All print material disseminated through the Lead information Line is provided by the EPA State Lead Program.
/2012/ The Division of Community Systems Development and Outreach (CSDO) State Lead Program , supported by the US Environmental Protection Agency (EPA), utilizes the Lead Abatement Training Center (LATC) in Danville, PA, and selected partner sites statewide, to provide Lead Contractor training services. Through a Memorandum of Understanding, the DPW provides physical plant oversight; the Department of Labor and Industry provides accreditation for trainers and certification for individuals successfully completing training. //2012//

The DCAHS and DPW contract with the four Family Health Councils to support family planning services at approximately 250 local clinics throughout Pennsylvania. Utilizing funding from different sources, services are reimbursed using a common fee schedule. Funding sources

include: Title V (for teens 17 and under), Title XIX, and Title XX, and state funding for breast cancer screening and women's medical services. The United States Department of Health and Human Services Title X funding is provided directly to the four Family Health Councils.

The Division of WIC collaborates with the Department of Public Welfare (DPW) to help ensure the eligibility of WIC applicants. Federal WIC regulations require that individuals meeting other WIC eligibility criteria be considered income eligible if they are currently receiving Medical Assistance (MA), SNAP (formerly Food Stamps), and/or Cash Assistance (TANF). In order to ease the burden of proof on WIC applicants and ensure more accurate and up to date data, the Division of WIC has collaborated with the Pennsylvania Department of Public Welfare to link into their Client Information System (CIS). The Division of WIC worked closely with DPW staff to ensure there were adequate security measures in place to insure the confidentiality of data and the integrity of DPW's CIS system. Procedures were put in place to insure access to CIS only by authorized WIC users and then only with secure password protection. This access to DPW data speeds the WIC certification process and provides up to date accurate information so there is less chance of inappropriate WIC certifications.

***/2013/ This partnership and communication continues today. A rollout of a new verification system is currently taking place and coordination efforts are underway to ensure the Quick WIC data system is utilizing the correct website for verification. //2013//***

The Bureau of Family Health routinely partners with DPW related to its administration of several programs utilized by MCH populations. Programs include state Medicaid (Medical Assistance), Early and Periodic Screening, Diagnosis and Treatment Program(EPSDT), mental health and substance abuse services (in conjunction with the Department of Health's Bureau of Drug and Alcohol Programs), developmental disability and early intervention, child welfare services including abuse, neglect, foster care and permanent placement, Temporary Assistance to Needy Families, and energy assistance services.
/2012/ The DCAHS is engaged in active collaboration with the DPW's Office of Early Child Development and Learning which was designated by former Governor Rendell to serve as Pennsylvania's Lead Agency for the Affordable Care Act Home Visitation Program. Title V offered support and guidance in OCDEL's Statewide Needs Assessment and has also reviewed data from that Needs Assessment to better inform the Title V Needs and Capacity Assessment completed last year. //2012//

Coordination with the Department of Education

The BrainSTEPS program represents a unique opportunity for the Division of Child and Adult Health Services (DCAHS) to partner with the Pennsylvania Department of Education (PDE) on an issue of importance across Departments. The partnership with PDE facilitated critical access to school districts across the Commonwealth. Additionally, through this partnership, PDE supported the development and implementation of an on-line database utilized for BrainSTEPS reporting. In September 2007, the DCAHS, through a partnership with the Brain Injury Association of Pennsylvania implemented a Child and Adolescent Brain Injury School Re-Entry program entitled BrainSTEPS (Strategies, Teaching Educators, Parents and Students). The goal of the BrainSTEPS program is to facilitate the transition of children and adolescents back into the educational system following a brain injury. Through this program, a link is established between the trauma centers/rehabilitation hospitals and the special education team within the school. Teams are established who are available to families and schools throughout the Commonwealth. BrainSTEPS teams assist local school staff in developing educational programs, academic interventions, strategy implementation and monitoring of students who have sustained a brain injury.

The DCAHS collaborates with the Department of Education on several initiatives related to teen pregnancy prevention and preconception health. The DCAHS has coordinated efforts with the Department of Education on grant applications that will bring approximately $2.2 million dollars of

federal funding per year for five years into Pennsylvania. This money will be used in a statewide initiative to implement a comprehensive, evidence based teen pregnancy curriculum in ten large school districts throughout the Commonwealth. Additionally, the DCAHS and the Department of Education have collaborated to promote preconception health strategies for adolescents in a Preconception Health for Adolescents Action Learning Collaborative sponsored by the Association of Maternal and Child Health Programs (AMCPH). The goal of this initiative is to increase parent, educator, and primary care giver's awareness about the stages of adolescent development and have the associated communication skills to discuss these issues with adolescents.

Coordination with Department of Agriculture

The Division of WIC (WIC) is also venturing into a new collaboration with the Pennsylvania Department of Agriculture for the pilot of a program that would allow the use of WIC Cash Value Vouchers (CVV's) at Department of Agriculture authorized Farmer's Markets. WIC has collaborated with Agriculture for many years in the distribution of WIC Farmer's Market Coupons each summer, but the introduction of WIC CVV's, which are check like drafts that allow the purchase of a fixed amount of fruits and vegetables each month, allow a new opportunity to partner with the Department of Agriculture and the Farmer's Market Nutrition Program (FMNP). The summer of 2010 WIC is piloting the use of WIC CVV's in Adams and Franklin Counties. It is hoped this pilot will increase the use of both WIC CVV's and FMNP coupons and will provide an increased business opportunity for the farmers and farmers markets in this area of the state. This pilot will be evaluated after the conclusion of the Farmer's Market season and a determination will be made as to whether or not the pilot will be rolled out statewide in 2011.
/2012/ The result of the pilot project for use of the WIC Cash Value Voucher (CVV) at Department of Agriculture authorized farm markets resulted in 67 individual CVV's being transacted at 6 of the 12 markets that initially were authorized and trained to transact these vouchers. The total dollar transactions for these 67 checks was $532.25. These transactions occurred from July 1, 2010 through November 30, 2010. During this same timeframe, 23 stores redeemed $102,541 in CVV's. Approximately 0.5% of all CVV transactions in Franklin and Adams counties during the five month period occurred at the Farmer's Markets. Based on these results, the State Agency has determined that it would not be cost effective to authorize and train all farm markets to transact the CVV's. //2012//

***/2013/ The Division of WIC's 24 local agency contractors continue the distribution of the annual farmers market vouchers to WIC participants. Outreach materials for this program are provided by the Department of Agriculture and regular updates are provided to the local agencies quarterly at the Local Agency Directors meetings held in Harrisburg. //2013//***

Coordination with the Department of Aging

The Division of Newborn Screening and Genetics (Division) has a Memorandum of Understanding (MOU) with the Department of Aging (PDA) that allows the Division to take advantage of PDA's Pharmaceutical Assistance Contracts for the Elderly (PACE). The PACE Program is a large pharmaceutical assistance program for low-income Pennsylvania residents over age 55. The MOU allows the Division to expand the number of accessible pharmacies and consolidate pharmaceutical claims processing through a single administrative agency. The PACE Program administers cardholder application, enrollment processing, and pharmaceutical claims processing that includes prescription and non-prescription drugs, medical supplies, nutritional supplements, incontinent supplies, durable medical equipment and metabolic formula for the Division's Children with Special Health Care Needs programs including Spina Bifida, Cystic Fibrosis, and Metabolic Conditions. The PACE contractor provides professional and technical support to the Division regarding pharmaceutical services, including medical exceptions, formulary review, reports and assessment of drug utilization surveillance review, prospective drug utilization, drug product research, and written reports regarding relevance to end stage renal

disease. In addition, PDA provides informal adjudication for any disputes arising from a pharmacy provider or cardholder enrollment, re-enrollment and eligibility, including denial of payment for claims submitted by providers and cardholder benefit cancellation, based on the requirement and appeal rights established by the Department of Health. ***/2013/ The MOU with PDA was renewed in August of 2012. //2013//***

Other Agency Coordinated Efforts

The Bureau works collaboratively with a number of community based organizations that are focused on parent education and leadership. Through the State Implementation Grant for Integrated Community Systems for Children and Youth with Special Health Care Needs, the PEAL (Parent Education, Advocacy and Leadership) Center provides parent leadership training to assist families in finding their voices and integrating them into the established Parent Youth Professional Forums. Additionally, PEAL has provided educational sessions on Medicaid 101 across the state to assist DOH in addressing the ongoing need for resources and information expressed by the parents and families. Other large parent organizations including Parent to Parent and the Parent Education Network (PEN) also belong to the regional forums and assist in addressing parent needs. Parents of CYSHCN in the military are reached through networking with Military One Source and providing information and resources to them.

## F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

***/2013/ From 2009-2010, asthma hospitalizations decreased 14.4% statewide, including a 7.6% decrease for children ages 0-4 (44.8 v. 48.5 admissions per 10,000). Black rates decreased 15.4% (52.1 v. 61.6 per 10,000) and Hispanic rates decreased 21.5% (27.7 v. 35.3 per 10,000). These decreases may be due, in part, to better outpatient management of asthma. However, asthma hospitalization rates increased 16.0% in 2009 compared to 2008 (48.5 vs. 41.8 admissions per 10,000). This increase may be related to rate increases in specific geographic areas of the state or increasing rates in specific ethnic or gender populations. //2013//***

***/2013/ The DOH Asthma Control Program received funding through the Centers for Disease Prevention and Control to implement the following interventions to reduce the burden of asthma statewide, particularly for disparate populations such as children, ethnic minorities and low-income residents. //2013//***

In 2010:
•Improving Performance In Practice (IPIP) program through the Pennsylvania Academy of Family Physicians Foundation intervention that provides consistent quality healthcare to pediatric patients with asthma in a standardized uniform approach.
•Healthy Homes Environmental Program (HHEP) in collaboration with DPW will increase the proportion of people with current asthma who report they have received self-management education as part of the (HHEP). ***/2013/ It has been reported that asthma programs with close ties to the community, with robust interactions with other agencies and with an intensive home trigger control component were most successful in reducing asthma hospitalizations. //2013//***
•Asthma 101 program reduces the number of asthma episodes among school-age students through educating school personnel. Asthma 101 will partner with Department of Health Learning Management System (LMS) to allow school personnel to obtain Continuing Education Units (CEUs).

In 2011:

•Increase from 16 to 20 the number of pediatric healthcare practices using IPIP to provide consistent quality healthcare to pediatric patients with asthma.
•Reduce inpatient asthma hospitalization rates among Medicaid recipients as part of the Healthy Home Environment Program. ***/2013/ Volumes were too small to calculate reliable hospitalization data. //2013//***
•Reduce the number of asthma episodes among school-age students through implementation of the Asthma 101 program.

In 2012:
***/2013/ Utilize Pennsylvania Asthma Surveillance System data to optimize resources to continually decrease health disparities among people with asthma. //2013//***
•Increase the number of health care providers who receive continuing education that directly links to the National Heart Lung and Blood Institute's National Asthma Education and Prevention Program Guidelines. ***/2013/ Over 650 physicians and nurses statewide have completed PA Medical Society Counter Details curricula regarding asthma adherence management and smoking impact on asthma. //2013//***
•Increase the number of individuals affected by asthma who report having a self-management intervention. ***/2013/ Participant enrollment exceeded target by 3.5%. //2013//***
•Improve asthma measures in 16 pediatric asthma practices in Pennsylvania. ***/2013/ Reduce the number of asthma episodes among school-aged children with asthma through implementation of the Asthma 101 program. About 100 school-based staff took Asthma 101, including the new Department of Health Learning Management System (LMS) to facilitate online Continuing Education Units (CEUs). //2013//***

***/2013/ In 2013:***
- ***Utilize Pennsylvania Asthma Surveillance System data to optimize resources to continually decrease health disparities among people with asthma.***
- ***Increase the number of people with asthma who report a self-management intervention through a community-based healthy home environment program providing in-home asthma trigger assessment, education and referral services for patients and caregivers.***
- ***Increase the number of health care providers who receive continuing education linked to the National Heart Lung and Blood Institute's National Asthma Education and Prevention Program (NAEPP) Guidelines.***
- ***Reduce the number of asthma episodes among people with asthma, especially children, through implementation of the Asthma 101 program and related curricula. //2013//***

***/2013/ Children who are at risk for lead poisoning are often also at risk for asthma exacerbation due to conditions within their homes. In order to address both conditions, the Childhood Lead Poisoning Prevention Program (CLPPP) has incorporated a "Healthy Home" checklist into home visits conducted by case managers for children with elevated lead levels. The checklist helps case managers to identify and provide education to families about behavioral or structural factors that may exacerbate asthma. //2013//***

Health Systems Capacity Indicator 02: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

***/2013/ Since the instructions for the CMS-416 Report had changed after the 2009 figures were reported numbers for 2010 and 2011 have decreased due to this change. As a result we are only able to compare 2011 data with 2010 data. The most recent figures show that there was less than a 2.0% increase from 2010 to 2011 of Medicaid enrollees whose age is less than one year during the reporting year who received at least one periodic screening. //2013//***

Health Systems Capacity Indicator 03: The percent State Children's Health Insurance Program

(SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

In June of 2008, the Insurance Department released revised 2008-2010 performance objectives for the Well-Child Visits in the First 15 Months of Life (W15) performance measure to the CHIP contractors, which included a comparison of performance over the previous three years and projections for the HEDIS 2008, HEDIS 2009 and HEDIS 2010 measurement years. In November 2009, the State revised the performance objectives for the W15 performance measure to include a comparison of performance over the previous three years and projections for the HEDIS 2010, HEDIS 2011 and HEDIS 2012 measurement years. In November 2010, the State revised the performance objectives for the W15 performance measure to account for HEDIS 2010 performance which included new projections for the HEDIS 2011, HEDIS 2012 and HEDIS 2013 measurement years.

Because the 6+ visits rate is the most preferred outcome, goals were set for this measure. The rate for this measure increased by approximately three percentage points (5.1 percent) for HEDIS 2010 which was above the performance goals established for HEDIS 2010, HEDIS 2011 and HEDIS 2012. Therefore the goal was set to increase this rate by one percentage point each year over the next three years in order to approximate the increase observed from HEDIS 2009 to HEDIS 2010. The above goals were adjusted in November 2010 from the goals set in November 2009 based on actual CHIP HEDIS 2010 performance and may be subject to change pending HEDIS 2011 results. An annual "report card" was developed for public reporting of multiple Pennsylvania CHIP performance measures including the W15 measure. This measure was first publicly reported beginning with HEDIS 2008 rates.

***/2013/ After an increase of 39.0% between 2006 and 2010 of SCHIP enrollees who received at least one periodic screening, there was a decrease of less than one percent to 86.6% in 2011. //2013//***

Health Systems Capacity Indicator 04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

***/2013/ There has been little change over the last five years with approximately 68.0% of Pennsylvania women receiving adequate prenatal care, according to the Kotelchuck Index. There has been a small improvement in each of the last four years, showing an increase of 2.3% from 65.6% reported in 2007 to 67.9% in 2010. Pennsylvania did not meet the Healthy People 2020 target of 77.6% for this indicator. Targeting interventions to address risk factors that lead to inadequate prenatal care is essential. The most common risk factors for lack of prenatal care include: being a victim of domestic violence, substance abuse, delivering a child before the age of 20 years old, low income, lack of a high school education, and being an undocumented immigrant. //2013//***

The Department continues to strive to remove barriers and enhance access to prenatal care, recognizing that early entry into prenatal care is one of the key components in the battle against infant mortality. The majority of the ten county/municipal health departments offer prenatal home visiting programs in an effort to reach at-risk or traditionally underserved mothers and families.

In addition to prenatal home visiting programs administered at the local level, the Department provides funding to support a Centering Pregnancy program administered by the Montgomery County Health Department. Centering Pregnancy programs are essentially group prenatal care which provide women with a support system as well as encouragement to receive regular prenatal checkups throughout the entire pregnancy. Centering Pregnancy programs have been shown to produce positive birth outcomes among participants in areas such as reducing preterm births, initiation of breastfeeding and maternal knowledge of pregnancy.

***/2013/ The DCAHS is working in partnership with the Albert Einstein Healthcare Network and Enon Tabernacle Baptist Church to implement a centering pregnancy program in a medically underserved area of Philadelphia. Centering pregnancy programs are essentially group prenatal care, which provide women with a support system as well as encouragement to receive regular prenatal checkups throughout the entire pregnancy. This initiative will enable at risk women to access prenatal care services within their neighborhood with a goal of improving birth outcomes. //2013//***

Health Systems Capacity Indicator 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

***/2013/ The percent of potentially Medicaid eligible children who have received a service paid for by the Medicaid program has remained relatively stable over the last five years, dropping by less than one percent from 2010 through 2011. However, the actual numbers of children receiving a service paid for by Medicaid has gone up in that time period by 32,164 individuals. At the same time the number of eligible children has also increased by a similar proportion, thereby keeping the percent relatively the same. //2013//***

Health Systems Capacity Indicator 07B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

The percent of EPSDT eligible children aged 6 through 9 receiving a dental service increased from 38.3% in 2006 to a high of 51.9% in 2010, representing an increase of 35.5% in dental services for this age group since 2006.

***/2013/ After a 35.5% rise of EPSDT eligible children aged 6 through 9 who reported receiving a dental service between 2006 and 2010, there was a slight drop of 1.3% in 2011 from 2010. However, the actual numbers of children receiving at least one dental service rose by 2,454. The reason for the drop in percent was that the number of children eligible for the services also rose for that year. //2013//***

The Department of Public Welfare continues to focus on dental care and making sure each child is referred to a dental home.

In the Access Plus program Pay for Performance Program for Dental providers was started on July 1, 2008. Dental providers are reimbursed if the meet performance measures in each of the four metrics. Dental care for children under 21 years of age is one of the metrics.

Under this metric the performance areas include:
1. Completing a first dental care visit with an Access Plus patient that includes a comprehensive oral evaluation, prophylaxis and fluoride treatment for patients = 16 years of age.
2. Completing a periodic dental care visit with an Access Plus patient = 21 years of age that includes a comprehensive oral evaluation, prophylaxis and fluoride treatment for patients = 17 years of age.
Completing an authorized scaling and root planning intervention with an ACCESS Plus patient.

Health Systems Capacity Indicator 08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

Due to small numbers trending is not possible for this Indicator. The Bureau funds services for individuals with complex medical conditions such as Hemophilia, Spina Bifida, Cooley's Anemia, Cystic Fibrosis, Child Rehabilitation, and Sickle Cell Disease through the Bureau's Comprehensive Specialty Care and Sickle Cell Disease Programs. Funding helps support Multidisciplinary Team Clinics at university-based medical centers. The one-stop multidisciplinary team clinic visits afford patients a full gamut of necessary services to manage their complex

medical condition. As the name "multidisciplinary" implies, the clinics support a broad array of service providers who collaborate to provide comprehensive care and coordinate care to a greater extent than typical insurance reimbursements would allow. In addition, they provide professional expertise and outreach to community-based provider networks, family members and school staff to help them manage and coordinate care for these complex medical conditions. Services include specialized physician and surgical care, nutrition, case management, social work services including psychosocial support and links to community resources, laboratory, radiology, pharmacology, speech therapy, physical therapy, occupational therapy, orthotic care, dental care and health education.

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

***/2013/ In 2010, the percent of low birth weight infants continued to be 50.0% higher in the Medicaid population (10.7%) compared to the non-Medicaid population (7.1%). Research has shown that Medicaid recipients continue to be at high risk for delivering low birth weight infants compared to non-Medicaid recipients. //2013//***

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

***/2013/ In 2010, the Title V program is not able to break down the infant deaths per 1,000 live births into Medicaid and non-Medicaid categories. After declining from 7.5 deaths per 1,000 live births in 2007 to 7.2 in 2009, the death rate has changed slightly to 7.3 per 1,000 in 2010. //2013//***

In December of 2010, Act 73 of 2010, Sudden Infant Death Syndrome Education and Prevention Program went into effect. The overarching goal of Act 73 is to provide education to new parents about the risks of SIDS and to provide information on safe sleep practices. The DCAHS has developed materials regarding SIDS and infant safe sleep and distributes materials to hospitals and healthcare providers.

Additionally, the DCAHS has implemented a statewide SIDS initiative aimed at developing a consistent message relating to SIDS and safe sleep practices. This initiative is administered through S.I.D.S of PA. In addition to the statewide program, the Bureau provided financial support to local agencies and organizations through small no-bid grants in an effort to decrease the incidence of infant death due to factors such as SIDS and accidental suffocation and strangulation of infants in unsafe sleep environments. These programs use Title V funding for activities and materials to improve the health and safety of infants and reduce infant mortality rates across the Commonwealth. Target populations receiving direct services through these programs include first time mothers, including teen mothers, and families residing in at-risk communities.

***/2013/ With funding from the DCAHS, S.I.D.S of PA is providing small no bid grant opportunities to begin Cribs for Kids(r) programs in underserved communities in the Commonwealth. The program will provide Pack n Plays to community members who do not have access to a safe sleep environment for their infant. Additionally, S.I.D.S of PA is conducting Symposiums across the Commonwealth to ensure that a consistent message related to SIDS and safe sleep is being provided to families. //2013//***

Health Systems Capacity Indicator 05C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

***/2013/ In 2010, the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester was 71.3% compared to 70.9% in 2009. Neither of these figures met the Healthy People 2020 target of 77.9%. Non-Medicaid recipients had a higher percent of receiving prenatal care in the first trimester compared to Medicaid recipients, 77.0% versus 59.3% in 2010. This represents no essential change from the 2009 data.***

***Maternal risk factors such as being a victim of domestic violence, suffering from depression, and substance abuse can all affect both prenatal care utilization and the prenatal outcome. These risk factors are overrepresented in the Medicaid population. //2013//***

The Bureau begun analyzing data collected through PRAMS, including initiation of prenatal care in order to implement specific evidence-based programming.

***/2013/ The Department now has two years of collected survey data from the Pennsylvania Pregnancy Risk Assessment Monitoring System (PA PRAMS). Bureau staff has begun and will continue to analyze this data with an eye toward identifying initiation rates across maternal demographics, prenatal care barriers and gaps in service. This data-based analysis will continue to inform programming. //2013//***

The Department administers early pregnancy testing clinics at the local level by the county/municipal health departments, which focus on early pregnancy testing to encourage early entry into prenatal care. Women seen at the clinic with positive pregnancy tests are offered assistance with scheduling prenatal care visits.

Two county municipal health departments administer programs specifically focused on prenatal care for women.

***/2013/ In addition to the two county municipal health departments that administer programs specifically focused on prenatal care, the DCAHS is providing funding for a centering pregnancy program to be administered in Philadelphia. The program location was specifically chosen to provide prenatal services to women at-risk for poor birth outcomes living in medically underserved areas. Centering pregnancy programs have improved prenatal care compliance among enrolled women. //2013//***

Health Systems Capacity Indicator 05D: Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])

***/2013/ In 2010, the percent of pregnant women on Medicaid who received adequate prenatal care before giving birth was 61.4% compared to 70.8% of non-Medicaid covered pregnant women who gave birth. These numbers reflect no change from those reported in 2009. //2013//***

***/2013/ Eight of the ten county municipal health departments provide home visiting services. Home visitors are in a unique position to emphasize the importance of regular prenatal care and ensure women are keeping medical appointments. County municipal health departments who provide early pregnancy testing offer all women with positive pregnancy results assistance in obtaining prenatal care as well as home visitation services. Additionally, women participating in centering pregnancy programs are more likely to receive adequate prenatal care, initiate breastfeeding and program participants have shown improved birth outcomes. //2013//***

Health Systems Capacity Indicator 06A: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)

The Medicaid income limits used to determine eligibility for pregnant women and infants up to age one is 185% Federal Poverty Income Guidelines (FPIG). On November 2, 2006, Governor Rendell signed into law Act 136 of 2006, making Cover All Kids a reality by expanding the income eligibility rules for the Children's Health Insurance Program (CHIP) and allowing the State to collect a monthly premium as permitted by the Federal Government. The CHIP expands medical coverage for families with an income over 300% of the federal poverty level. The "Cover All Kids" initiative could potentially provide medical insurance for families with children with special health

care needs that are ineligible for the Medicaid Program. The initiative enables qualified families to purchase coverage at the Commonwealth's rate of $150.00 a month per child, potentially assisting children with special health care needs that are ineligible for Medicaid. To receive CHIP coverage for free, children must be in households with incomes no greater than 200% of poverty. Children in households with incomes between 200% and 300% of poverty can receive coverage by paying a low monthly premium that is adjusted according to income. Children in households with incomes above 300% of poverty may purchase coverage at the full state-negotiated rate. A current policy dictates that children eligible for Medical Assistance cannot be also enrolled in CHIP.

While not studied specifically, the "Cover All Kids" initiative has potentially provided medical insurance for families with children with special health care needs that would be ineligible for the Medicaid program.

Health Systems Capacity Indicator 06B: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children

The Medicaid income limits used to determine eligibility for age one to age six is 133% of Federal Poverty Income Guidelines.

Despite budgetary pressures, the income thresholds to qualify for CHIP have not changed since the expansion of the income guidelines in 2007. To qualify for CHIP, household income must be above the upper limit for Medicaid and not exceed the following guidelines for varying degrees of government subsidization:

Free CHIP (100% subsidy) = 200% of the federal poverty level
Low cost CHIP (75% subsidy) = 250% of the federal poverty level
Low cost CHIP (65% subsidy) = 275% of the federal poverty level
Low cost CHIP (60% subsidy) = 300% of the federal poverty level
Full cost CHIP (no subsidy) = incomes above 300% of the federal poverty level

The income thresholds to qualify for Medicaid and CHIP were increased effective January 20, 2011 based on a Federal decision to increase the Federal Poverty Income Guideline amounts.

Health Systems Capacity Indicator 06C: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women

The Insurance Department refers pregnant teens to Medicaid whenever an application denotes such a pregnancy. As noted above, children eligible for Medicaid are not eligible for CHIP. In order to maintain continuity, however, CHIP members who become pregnant after becoming enrollees are maintained in the program up to 31 days after delivery. CHIP contractors are required to initiate the Medicaid application process prior to the 31 days expiration period to ensure the CHIP member and baby do not have a lapse in coverage while determining eligibility for either program.

Health Systems Capacity Indicator 09A: The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

The Bureau established seven strategies associated to the State Systems Development Initiative HRSA grant award in 2006: link birth records to newborn screening files; match birth record to WIC files; improve newborn screening links; integrate PRAMS data into other DOH programs; explore DOH and MA file links; match NSFP files to death records; and match birth and death records to hospital discharges for birth defects surveillance.

***/2013/ The initial SSDI grant ended January 31, 2012. The objective of the grant was to collaborate with public and private health partners to develop and sustain data linkages to***

***improve access to maternal and child health information. The majority of the objectives were met or will be implemented when the Department's new birth records system is activated. Efforts will continue to address those objectives not yet implemented.***

***The Department received a new SSDI grant award on March 7, 2012 to strategically integrate existing health information systems and apply the information garnered to the development of a Birth Defects Surveillance System. //2013//***

***/2013/ Data briefs and reports reflecting analysis on various topics and variables have been generated and distributed internally and externally across Pennsylvania's maternal and infant health serving community. Data briefs on alcohol use during pregnancy, postpartum depression and SIDS have been finalized. Additionally, reports on the above topics as well as on pregnancy intendedness, birth weight, breastfeeding, and maternal demographics have been completed and disseminated. PA PRAMS analysis on breastfeeding prevalence was recently completed on behalf of the Breastfeeding Awareness and Support Program. The report spans a wide range of cross tabulations related to Pennsylvania's breastfeeding prevalence and maternal demographics. Ongoing collaborative relationships with the Pennsylvania Perinatal Partnership (PPP) and the MCH/PRAMS Advisory Committee generate analysis and reporting priorities for PA PRAMS. Reports and data briefs will continue to inform MCH programming policies and priorities, and support effective evaluation. //2013//***

Health Systems Capacity Indicator 09B: The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.

***/2013/ The statewide initiative, Pennsylvania's 100% Tobacco Free Schools Toolkit for Student Assistance Programs, is a multi-agency coordinated effort to provide regional trainings to promote awareness and expansion of tobacco-free school policies across the commonwealth, utilizing the resources of the Department of Education Student Assistance Programs, the Department of Public Welfare, and the Department, Bureau of Drug and Alcohol Programs and the DTPC. The training is endorsed and supported by the Student Assistance Program (SAP) Interagency Committee.***

***Pennsylvania's 100% Tobacco Free Schools Toolkit incorporates CDC guidelines for schools to implement a 100% tobacco-free policy that prohibits the use of tobacco products in any form, by anyone, on any occasion and at any time on school grounds, in school vehicles and at school-sponsored events on or off campus. This policy is enforced 24 hours a day, seven days a week.***

***In November 2010, a two day train-the-trainer (TOT) conference was conducted in Pittsburgh to train Regional Primary Contractors who would implement the Tobacco Free Schools initiative and strengthen school-based tobacco policies. The training was supplemented by extensive written material including Pennsylvania's 100% Tobacco Free Schools Toolkit, a TOT manual and other background material, including the School Tobacco Policy Index and Rating Manual developed by the Center for Tobacco Policy Research in partnership with the CDC. The School Tobacco Policy Index is a tool for tobacco control practitioners and educational leaders to systematically evaluate the comprehensiveness of school tobacco control policies based on four domains: 1) tobacco-free environment; 2) enforcement; 3) prevention and treatment services; and 4) policy organization.***

***Eight Regional Primary Contractors are responsible for targeting and recruiting schools within their respective region. Policy assessments, including cessation policies and interventions, provide baseline information about existing policies among participating schools. Pennsylvania's Regional Primary Contractors and their Service Providers are***

***working with schools to utilize the School Tobacco Policy Index to evaluate the comprehensiveness of school tobacco policies. Evaluation efforts have been useful in strengthening existing policies and developing new comprehensive policies to protect the health of students, staff, administrators and visitors. During this report period, Regional Primary Contractors worked with 79 schools to establish/create new tobacco policies, 158 schools to strengthen existing policies, and 120 schools on enforcement of school policies. At least 25 schools were identified as making at least one policy change. //2013//***

# IV. Priorities, Performance and Program Activities

## A. Background and Overview

The Bureau of Family Health, contracted with REDA International, Inc. in 2009-10 to conduct a five year statewide assessment of maternal, child and family health. This process is described earlier in this application. The purpose of this assessment of maternal, child and family health was to gather and present current information about the health and well being of the women, infants, children and children with special health care needs (CSHCN) residing in the Commonwealth. The assessment was conducted under the auspices of the Federal Title V Maternal and Child Health Program in accordance to the mandate to states to conduct an in depth maternal and child health needs and capacity assessment every five years.

The Bureau of Family Health assembled Title V stakeholders from across the state of Pennsylvania for the purpose of prioritizing Title V needs. The Bureau contracted with a nationally recognized expert, Andrew C. Rucks, Ph.D., University of Alabama-Birmingham, to facilitate the priority setting process using the Q-Sort technique. The purpose of the Q-Sort process is to identify priorities among competing needs. However, not all needs can be the "highest priority" for the state MCH program. The Q-Sort Technique is effective at getting information from people with different backgrounds.

A set of 50 "priority needs" was provided to the MCH stakeholders based upon the results of the Needs and Capacity Assessment. Each priority need was assigned a numeral as a label, with the labels having no relationship to priority order or value of the priority need. The set of 50 priority needs were converted to decks of 50, 3inch-by-5inch cards. Each card contained a label and its associated Priority Need Statement. Stakeholders were assembled in large room set-up in classroom style with tables. Each stakeholder was given one deck of cards and two Q-Sort Log Sheets . Dr. Rucks presented the group with: 1) an overview of the Q-Sort technique; 2) an overview of the strategy for arranging Priority Need Statements into priority sets; 3) specific instructions about placing the cards in descending order of priority and how to complete the Log Sheet; and 4) a presentation of the results of analyzing the data collected using the Log Sheets.

The assembled stakeholders applied the Q-Sort technique to assign each of the 50 Priority Need Statements to one of nine priority categories. Data generated by the stakeholders was analyzed using the traditional technique applied to Q-Sort data and enhanced analysis to offer additional information to the Title V decision makers. Consensus was reached by the stakeholders on the categorical assignment of 39 of the 50 Priority Need Statements.

Priorities were ranked according to the three populations to be served by Title V including: pregnant women and mothers, children, and children with special health care needs. An overarching priority of developing a comprehensive, cohesive statewide MCH policy is necessary to serve as a "catch-all" for priorities identified that cross multiple state agencies or funding sources and those which require attention at the Governor's level (these issues include: ensuring all Pennsylvanians have affordable health insurance, integrate behavioral and physical health care, improve access to oral health services, comprehensive programming to address obesity, expanding the number of providers who serve low income and uninsured individuals, expanding availability of dental care providers accepting Medicaid in underserved areas).

As a result of the Q-Sort technique and stakeholder consensus, the Bureau has selected the following 10 priorities (it should be noted some priorities were collapsed or combined where determined appropriate and feasible and any priority that is a state mandate (e.g. Newborn Screening) or Governor's Office initiative (e.g. Medical Home) was excluded from the list.

Items 1-3 are priorities related to Mothers and Infants. Item number 1 was the highest ranked (weighted) item in the Mothers and Infants category, followed by numbers 2 and 3 respectively. Items 4-7 are priorities related to Children and Adolescents. Within this cluster, item 4 was the

highest ranked (weighted) item in the Children and Adolescent category followed by numbers 5, 6 and 7 respectively. Items 8-10 are priorities related to Children with Special Health Care Needs (CSHCN). Within this cluster, item 8 was the most highly ranked (weighted) in the CSHCN category, followed by items 9 and 10, respectively.

1. Decrease barriers for prenatal care for at-risk/uninsured women through implementation of best practices
2. Reduce infant mortality rate for minorities
3. Increase behavioral health (mental health and substance abuse) screening, diagnosis and treatment for pregnant women and mothers (this includes post partum depression)
4. Decrease teen pregnancy through comprehensive sex education
5. Increase screening for mental health issues among infants, children and adolescents
6. Expand access to physical and behavioral health services for high risk youth such as LGBTQ, runaway/homeless
7. Expand injury prevention activities (including suicide prevention), for infants, children and adolescents
8. Increase awareness of and access to comprehensive information about services and programs for CSHCN
9. Improve the transition of children and youth with special health care needs (CYSHCN) from child to adult medical, educational and social services
10. Identify strategies for increasing respite care for caregivers

## B. State Priorities

1. Decrease barriers for prenatal care for at-risk/uninsured women through implementation of best practices

Barriers to prenatal care, particularly for low income, at risk families are significant. The BFH will explore what best practice models could be introduced within the framework of existing programs. For example, Centering Pregnancy Initiatives have shown promise. The BFH will work with stakeholders to identify and address structural barriers such as wait times, inflexible scheduling and waiting room accommodations. Linguistic and cultural competency issues among providers are other key barriers that must be addressed. In one promising strategy, Medicaid has eliminated lag times associated with determining eligibility for pregnant women. Temporary outpatient prenatal services are provided to pregnant women determined to be presumptively eligible. The Medicaid program has increased fees for certain high risk pregnant women enrolled in Healthy Beginnings plus. Additionally, the Medicaid program has set aside dedicated funding to insure the availability of quality obstetrical and neonatal health care services for low income pregnant women.

***/2013/ The DCAHS is working in partnership with the Albert Einstein Healthcare Network and Enon Tabernacle Baptist Church to partner in developing and implementing a centering pregnancy program in Philadelphia. //2013//***

2. Reduce infant mortality rate for minorities

The BFH will address the high infant mortality rate among blacks through a variety of initiatives that involve partnerships between federal, state, and local governments, hospitals, and academic institutions, faith based organizations, and the community. To the degree possible the BFH is interested in implementing the Life Course Model in its various grant agreements with provider agencies and local Title V agencies. Pennsylvania is in the preliminary stages of implementing a home visiting program in conjunction with the Federal Maternal, Infant and Early Childhood home visiting program.

In addition, the mission of the BFH Newborn Screening Program (NSP) is to eliminate or reduce the mortality, morbidity, and disabilities that result from the disorders included in the screening panel, and the rapid follow-up of all infants with an abnormal screening test result. The primary function of the NSP's follow-up component is to locate infants with screening results that are screen positive and to facilitate the entry of these infants into the diagnostic and management components of the Newborn Screening and Follow-up Program in a timely fashion.

***/2013/ With the passage of Act 73 of 2010 every woman and/or family in Pennsylvania who has a newborn will receive information related to Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death (SUID) and safe sleep recommendations. //2013//***

3. Increase behavioral health (mental health and substance abuse) screening, diagnosis and treatment for pregnant women and mothers (this includes post partum depression)

Depression in pregnant women and mothers poses serious risks to children in Pennsylvania each day, yet very often goes undetected and untreated. Depression in pregnant women and mothers poses serious risks to children in Pennsylvania each day, yet very often goes undetected and untreated.

According to Vericker, Macomber, and Golden, 11% of infants living in poverty have a mother suffering from severe depression, and compared with their peers with non-depressed mothers, infants living in poverty with severely depressed mother are more likely to have mothers who also struggle with domestic violence and substance abuse (Urban Institute. Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve. Brief 1, August 2010). Vericker et al., also point out that the majority of infants with severely depressed mothers (96%) live with someone who received benefits from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

Because WIC is a first intervention point to reach many low-income mothers, the BFH will offer behavioral health screening and referral for women at participating WIC clinics and/or their umbrella agencies through the use of MCH/SHCN Consultants or other state health staff. The BFH will research appropriate screening tools; the Institute for Health and Recovery's "5 P's" screening tool shows promise for utilization in WIC clinics with the target population.

Pennsylvania's County Municipal health departments have integrated screening for perinatal depression into their prenatal and postpartum home visiting programs. The Department of Public Welfare, recognizing the need to improve social-emotional outcomes for young children convened the Early Childhood mental Health Advisory Committee. In 2009, this Committee issued formal recommendations which include improving access to and coordination of services for young children and promoting competencies among professionals that serve children ages 0 to 5.

***/2013/ The county municipal health departments continue to conduct depression screenings on women enrolled in home visiting programs. Women are referred, as needed, to mental health services. //2013//***

4. Decrease teen pregnancy through comprehensive sex education

Pennsylvania continues to work to decrease the teen pregnancy rate. The BFH has applied for the Tier One Teenage Pregnancy Prevention: Replication of Evidence-based Programs funding. If selected for funding, these funds would be used to implement the evidence-based program "Making Proud Choices" in schools, in the community through county/municipal health departments and a family health council. The BFH has also applied for the State Personal Responsibility and Education Program (PREP) funds. The PREP funds are formula grants to states. PREP funds will be used to implement an evidence-based program and to educate youth on adulthood preparation subjects in juvenile detention facilities, drug and alcohol treatment facilities, and mental health treatment facilities. The BFH has applied for the Title V State

Abstinence Education Grant. The Abstinence Education funds will be used to implement an evidence-based abstinence program with the following population groups: black and/or Hispanic youth, youth in foster care, and youth with disabilities and/or other special health care needs. Finally, the BFH continues to fund the four family planning councils in the Commonwealth to provide reproductive health services to teens 17 years of age and younger. The Department of Education(PDE) and the Department of Public Welfare (DPW) have collaborated in a joint effort to assist expectant and parenting youth receiving TANF or SNAP through the Education Leading to Employment and Career Training (ELECT) Program. ELECT program services include support through education groups, individual meetings, and curriculum-driven courses. These programs also provide intensive case management, attendance monitoring, and secondary pregnancy prevention. In 2008-09 the ELECT program enrolled a diverse group of 5,291 secondary school students at-risk for academic failure because they are pregnant or parenting. In addition, the Department of Education has applied for federal funds to support pregnant and parenting teens. If awarded the Department of Education will use these funds to provide services similar to the services provided in the ELECT program to teens who are not eligible for the ELECT program.

5. Increase screening for mental health issues among infants, children and adolescents

Poor circumstances, negative early experiences and lack of emotional support during normal growth and development can form the basis of the individual's human capital, which affects health throughout life. As cognitive, emotional and sensory development occur insecure or poor emotional attachment can lead to reduced readiness for school, low educational attainment and problem behavior in adolescents.

Because WIC is a first intervention point to reach many low-income infants and children, the BFH will offer mental health screening and referral at participating WIC clinics and/or their umbrella agencies through the use of MCH/SHCN Consultants or other state health staff. The BFH will research appropriate screening tools for infant and child mental health.

The Department of Public Welfare's Office of Mental Health and Substance Abuse Services was recently awarded a Garrett Lee Smith Grant. The Garrett Lee Smith Memorial Act provides funding for States, tribes and colleges/universities to develop and implement youth, adolescent and college-age early intervention and prevention strategies to reduce suicide.

***/2013/ Many county municipal health departments have replaced the previous developmental tool, the Denver Developmental Screening Test, with the Ages and Stages developmental screening tool. //2013//***

6. Expand access to physical and behavioral health services for high risk youth such as LGBTQ, runaway/homeless

The health needs of lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth are often not known by research and health authorities, and even when known, are often ignored and/or underfunded. Currently there are no known specific statewide programs that address the health issues faced by LGBTQ and/or runaway/homeless youth. The BFH will work with adolescent health, mental health, and drug and alcohol clinics to target LGBTQ youth. Few providers target LGBTQ youth with marketing and outreach. LGBTQ youth are likely to respond favorably to advertisements in local LGBTQ service directory and publications. In order to ensure that providers create a welcoming environment the BFH will provide cultural competency training to participating providers.

7. Expand injury prevention activities (including suicide prevention), for infants, children and adolescents

The Commonwealth currently engages in a number of activities aimed at expanding injury prevention for infants, children and adolescents. Notably, the Department of Health is

responsible for administering the Commonwealth's Child Death Review (CDR) Program. The goal of CDR is to reduce the incidence of preventable child deaths through the multi-disciplinary reviews of child deaths and through the implementation of targeted prevention efforts aimed at Pennsylvania's most vulnerable populations. Additionally, the Department administers the Violence and Injury Prevention Program and oversees the Injury Community Planning Group (ICPG). The ICPG endeavors to develop a comprehensive and coordinated injury prevention effort.

Pennsylvania is also home to the Cribs for Kids safe sleep initiative. Cribs for Kids is a safe-sleep education program for low-income families aimed at reducing the risk of injury and death of infants due to unsafe sleep environments.

As part of the Federal Traumatic Brain Injury (TBI) grant, the Department of Health is the lead agency in a number of initiatives aimed at increasing awareness regarding brain injury. These activities consist of providing TBI education in child care facilities including revising the Safe Active Play self learning module to include information about TBI, partnering with the Pennsylvania Chapter American Academy of Pediatrics to provide continuing medical education trainings to physicians, pediatric practices and family physicians and increasing TBI screening opportunities for victims of domestic violence and their children.

8. Increase awareness of and access to comprehensive information about services and programs for CSHCN

The Bureau of Family Health's Special Kids Network (SKN) helpline within the statewide Health and Human Services Call Center (HHSCC) is a free statewide resource for families with individuals who have special need and links callers to a broad range of services specifically CYSHCN. Through the Special Kids Network System of Care (SOC), the Bureau of Community Health Systems' Family Health Nursing Services Consultants (FHNSC) also link individuals to needed services, identify services in their communities, coordinate follow up referrals for services through the SKN Helpline, and convene Parent Youth Professional Forums statewide to provide input on programs and services as well as opportunities for family centered input on how to improve the systems and services for CYSHCN. The Pennsylvania Chapter of American Academy of Pediatrics (PA AAP) Medical Home program and the Pennsylvania Elks Home Service Program provide a roadmap to care through community based care coordination to families of CYSHCN. PA AAP's 121 Medical Home Practices provide information to families about services as central caregivers for CYSHCN. Another source of positive impact on access to information for families of CYSHCN is the PA CARES Task Force. This task force is a diverse organization that locates and identifies services for military and veteran families who are geographically dispersed throughout Pennsylvania and experience limited access to comprehensive information about services and programs in their state and communities. The PA Developmental Disabilities Council and the Governor's Advisory Committee for People with Disabilities, both housed in the Department of Public Welfare (DPW), identify and fill gaps in services, and DPW also provides a forum for distributing information via the Disability Advocacy and Support Hub and Home and Community Based Services forums. Some of these programs (such as SOC) are young and activities should produce a noticeable increase in access to information; most are well-established and have the capacity to develop new initiatives to impact access to information.

***/2013/ To assist families in finding information and utilizing needed services, a care coordination initiative was developed with the Elks Home Services Program (Elks). Families are referred to the Elks from a variety of sources when it is felt the child and/or family is in need of a more intensive level of assistance to obtain needed information and services. A nurse from the Elks is then assigned to the family to work with them directly to obtain needed services. Relates to NPM 5. //2013//***

9. Improve the transition of children and youth with special health care needs from child to adult

medical, educational, and social services.

Pennsylvania is committed to the philosophy that children and youth with special health care needs are entitled to fully participate within their communities and their schools, and enjoy full adult lives. This year the Transition State Leadership Team (SLT), consisting of designees from the Departments of Health, Education, Public Welfare, Labor and Industry, has revised the Memorandum of Understand for a Shared Agenda for Youth and Young Adults with Disabilities. This renew efforts reflects our commitment to work together to support youth and young adults with disabilities to transition into adult life in the achievement of their desired post-school outcomes, with a focus healthy lifestyles, secondary education, training and lifelong learning, employment, and community participation. The Pennsylvania Community on Transition Conference has signified the importance of health for transitioning youth and young adults by adding a "health track" this year. Through collaboration with the Pennsylvania Chapter of the American Academy of Pediatrics (PA AAP) and the bureau, this "health track" yielded 18 health related sessions that were very informative and well received. Its success has lead to the inclusion of the track in next year's conference planning activities. Through the work of the State Implementation Grant for Integrated Community Systems for Children with Special Health Care Needs, a Transition Learning Collaborative has been initiated. This group involves 25 public and private professionals, youth and parents in four work groups on transition: Resource Identification, Integration of Disciplines, Medical Provider Issues and Youth Wellness/Self Advocacy. In addition, three medical practice sites (Pittsburgh, Allentown and Reading) are involved in transition pilot projects.

***/2013/ The transition related state priority is being addressed through the PA Medical Home Program. Focus of activities is on creating a seamless healthcare transition for youth with special health care needs as they 'age' out of pediatric care and into adult health care. Transition protocols and policies are being developed for practices, youth and family leadership within medical home activities is being strengthened, and adult practitioners are being engaged in the transition process. Relates to NPM 6. //2013//***

10. Identify strategies for increasing respite care for caregivers

Pennsylvania is one of the twelve new states that have been awarded the Lifespan Respite Grant through the US Administration on Aging. Through collaboration with the Pennsylvania Lifespan Respite Coalition, the Department of Public Welfare (DPW), the Department of Aging, Pennsylvania's network of Aging and Disability Resource Centers, and the Department of Health (Special Kids Network System of Care/Medical Home Program) the Commonwealth will enhance and expand opportunities for respite care across all ages including CYSHCN, and adults with disabilities and the elderly. Under this grant collaborating state agencies will work with existing local community and statewide resources to make it easier for families to access respite services. The Special Kids Network System of Care and the Lifespan Respite Coalition will update the Family Guide to Respite Care which identifies what respite care is and how to coordinate it and provides information on existing services, their eligibility requirements, and how services are provided. This effort will increase awareness and access to services as well as expand and strengthen respite care services to family caregivers of children or adults of all ages with special needs. Grantees will also strengthen statewide dissemination and coordination of respite care, improve access to respite programs, and enhance the quality of respite care services. The ultimate goal of these activities is the reduction of family caregiver strain.

***/2013/ The Pennsylvania Lifespan Respite Grant Advisory Council (Council) was formed and includes twenty-five members appointed by the Secretary of Aging to lead, support and monitor the development of a statewide lifespan respite care system. The Council developed a grant program and made opportunities available throughout the state to target the unmet need of respite provision, particularly in emergency situations, and has published information on Pennsylvania respite care providers into the ARCH National Respite Network and Resource Center's National Respite Locator.***

***To increase the number of respite providers, the Department will fund faith-based organizations in Pennsylvania to engage their membership, and support the training of trainers in the provision of respite care. Funding will promote the development of a cadre of providers of respite care for caregivers of children with special health care needs. Respite care provided by or in partnership with parish nurses and others within churches/faith based organizations will be available to families who have children with medical conditions that require a level of care beyond what a non-medically oriented volunteer could provide. A second level of care will also be developed to provide respite care for children whose medical condition does not warrant a medically trained person. Relates to NPM 2 and 5. //2013//***

## C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 200 | 211 | 289 | 345 | 289 |
| Denominator | 200 | 211 | 289 | 345 | 289 |
| Data Source | | See field level note | See field level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2011**
Source: Division of Newborn Screening and Genetics

**Notes - 2010**
Source: Division of Newborn Screening and Genetics

**Notes - 2009**
Source: Division of Newborn Screening and Genetics

**a. Last Year's Accomplishments**
Approximately 142,000 newborns were screened in 2011 with follow up provided for all abnormal results to include the coordination of obtaining filter papers for repeat testing and referrals to treatment centers for confirmatory testing and diagnosis. The NSFP continues to learn more about the expanded screening for the additional metabolic and genetic conditions required by Act 36 and has adjusted program data elements and quality assurance components as necessary. The NSFP worked with its Technical Advisory Board to prepare for possible inclusion of Critical

Congenital Heart Disease and Severe Combined Immunodeficiency to the newborn screening panel. Subcommittees of the TAB met to discuss the inclusion of the CLSI Algorithm for Newborn Screening of Preterm, Low Birth Weight an Sick Newborns as well as modifications to the Filter Paper Specimen Retention policy.

In 2011, the following diagnoses were confirmed by the treatment centers: 22 Phenylketonuria; 0 Maple Syrup Urine Disease; 54 Congenital Hypothyroidism; 15 Galactosemia; 85 Sickle Cell Disease; 13 Congenital Adrenal Hyperplasia; 9 Amino Acid Disorders; 32 Acylcarnitine Disorders; 25 Biotinidase Deficiency and 38 Cystic Fibrosis Disease with 84 CF Carriers identified. Although Act 36 does not require follow up for Cystic Fibrosis carrier or other hemoglobinopathy traits, the NSFP coordinates the follow up process with the treatment centers to ensure that parents receive appropriate testing, counseling and education.

An Act 36 stakeholder meeting was held on January 11, 2011 to update the participants on the NSFP and the follow up elements established as a result of Act 36 implementation of 2009. The NSFP budget has seen reductions and the sustainability of the testing, treatment center funding and the formula program was discussed. The result was correspondence generated to the Secretary of Health by the Technical Advisory Board for the consideration of initiating a filter paper fee.

The NSFP continues to administer the metabolic formula program for clients with Phenylketonuria through the age of 21 for males and through childbearing age for females pursuing pregnancy. Eligibility is determined yearly and products must be distributed through the pharmacy network via a physician's prescription.

The NSFP worked extensively with the Cystic Fibrosis Treatment Centers. A need to educate PCPs had been identified as many have never seen a CF client in their practice. PCPs also need education on carrier status and the importance of obtaining sweat testing at a laboratory accredited for this confirmatory test. Materials had to be developed and the diagnosis process has been adjusted to help providers better serve clients with CF. The NSFP also worked with the CF Foundation to get an additional location accredited to perform CF sweat testing.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Coordinated statewide collection of a newborn screen bloodspot filter paper for 150,000 births a year. | X | | | |
| 2. Contracted with two newborn screening laboratories to complete newborn screening on all newborns. | X | | X | X |
| 3. Assured case management in recommendations of referrals for confirmatory testing, assessment, and diagnosis. | | X | X | X |
| 4. Contracted with treatment centers to conduct case management, confirmatory testing, assessment and diagnosis and treatment. | X | | | |
| 5. Worked with vendors to develop a newborn screening data system to replace the current system and include expansion of follow-up for 22 additional conditions. | | | | X |
| 6. Collaborated with genetic/metabolic specialists to integrate a medical home model for newborns diagnosed with metabolic/genetic conditions. | X | X | X | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |

| | | | | |
|---|---|---|---|---|
| 10. | | | | |

**b. Current Activities**
The NSFP is currently working with the Technical Advisory Board on a number of areas: Algorithm for Newborn Screening of Preterm, Low Birth Weight and Sick Newborns, filter paper retention policy, and the addition of Severe Combined Immune Deficiency (SCID), and Critical Congenital Heart Disease to the newborn screening panel. The NSFP is currently working through the procurement process to obtain a new medical consultant for the program.

The NSFP administers a statewide metabolic pharmacy program that enables clients with PKU to obtain metabolic formula at their pharmacy. The NSFP works with the Departments of Aging and Welfare to broaden financial coverage of metabolic formula.

The NSFP continues to work with CF Treatment Centers to facilitate the referral process. The NSFP will meet with the treatment center staff in May to review data collection and reporting and to monitor the educational materials in use.

The NSFP completed contract monitoring visits to all treatment centers and has developed reporting adjustments that will enhance the collaboration of the treatment centers with the Department. The NSFP has expanded its use of electronic notification and the use of secure email. New Participating Laboratory agreements with PerkinElmer Genetics and New England Newborn Screening Program were signed on April 1, 2012.

**c. Plan for the Coming Year**
The NSFP will participate in Secretary Sebelius' Advisory Committee on Heritable Disorders in Newborns and Children as appropriate. The NSFP will intensify its educational and outreach efforts to meet the needs of stakeholders, hospitals, primary care physicians, coordinators, treatment centers and community health nurses.

The NSFP is working on the addition of CHD to the newborn screening panel. Hospitals were preliminarily surveyed to determine current status and capacity for referral and treatment. This program will be part of the broadened Point of Care Section (formerly Hearing) with a possible implementation date of January 1, 2013. The NSFP continues to monitor national information regarding SCID, moving toward the future inclusion of this condition for follow up. Currently, about 30% of hospitals in PA offer SCID screening.

The NSFP plans to hold ongoing meetings with the Technical Advisory Board to continue to keep program activities in line with federal activity.

The NSFP will be releasing requirements for a data management system. This system must interface with OZeSP for Hearing Screening and will include a birth defects surveillance system.

## Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

| | |
|---|---|
| **Total Births by Occurrence:** | **142135** |
| **Reporting** | **2011** |

| Year: | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Screening Tests:** | **(A) Receiving at least one Screen (1)** | | **(B) No. of Presumptive Positive Screens** | **(C) No. Confirmed Cases (2)** | **(D) Needing Treatment that Received Treatment (3)** | |
| | No. | % | No. | No. | No. | % |
| Phenylketonuria (Classical) | 142135 | 100.0 | 22 | 22 | 22 | 100.0 |
| Congenital Hypothyroidism (Classical) | 142135 | 100.0 | 75 | 55 | 55 | 100.0 |
| Galactosemia (Classical) | 142135 | 100.0 | 22 | 13 | 13 | 100.0 |
| Sickle Cell Disease | 142135 | 100.0 | 93 | 85 | 85 | 100.0 |
| Biotinidase Deficiency | 141877 | 99.8 | 72 | 24 | 24 | 100.0 |
| Cystic Fibrosis | 141877 | 99.8 | 163 | 37 | 37 | 100.0 |
| Maple Syrup Urine Disease | 142135 | 100.0 | 2 | 0 | 0 | |
| Acylcarnitine | 141877 | 99.8 | 47 | 33 | 33 | 100.0 |
| 21-Hydroxylase Deficient Congenital Adrenal Hyperplasia | 142135 | 100.0 | 91 | 13 | 13 | 100.0 |
| Aminio Acids | 141877 | 99.8 | 40 | 7 | 7 | 100.0 |

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 73 | 73 | 60.6 | 60.6 | 60.6 |
| Annual Indicator | 60.6 | 60.6 | 60.6 | 60.6 | 73.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | See field level note | See field level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 73.1 | 73.1 | 73.1 | 73.1 | 73.1 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

**Notes - 2009**
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available.
The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

**a. Last Year's Accomplishments**
During 2011, the Pennsylvania Tourette Syndrome Alliance (PA-TSA) served a total of 3,836 children and 1,397 adults, attended 53 school meetings as members of the Individualized Education Plan (IEP) and Multidisciplinary teams; provided 15 educational trainings/presentations to educators, nurses and other professionals and trained 323 students about Tourette Syndrome (TS). Family representation is evident at all levels of service provision, from inclusion in board meetings to presence at all school meetings related to their children. Families continue to be satisfied with advocacy services, with 100% of families surveyed indicating that advocates gave emotional support and accurate information, and 90.0% indicating that advocacy services resulted in an appropriate education plan or accommodations for their child an increase from 77.0% in 2010. PA-TSA started an online support group on their website. The group, comprised of parents, teens and adults with TS, and professionals and staff of PA-TSA, functions as a message board, allowing members to ask questions and request support.

Parent partners are a critical component of the pediatric primary care teams that are part of the Pennsylvania Medical Home Program (MH Program). A parent partner is a parent or caregiver of a child or youth with special health care needs who assists a practice by offering guidance, participating in decision making and improving the quality of the practice for families. Key accomplishments included developing community resource flyers, creating resource bulletin boards, planning resource nights, mentoring other parents in a practice, working with practices to facilitate referral processes and developing pre-visit contact questions. In an effort to increase the number of parent partners in the Program, practices having difficulty recruiting and retaining Parent Partners were identified and provided with individualized technical assistance. As a result of these efforts, the number of parent partners increased significantly across the state from 91 in June 2011 to 129 by December 2011, a 42.0% increase.

In December of 2011, the Bureau of Family Health hired a parent of a child with special needs to be the Parent Advisor (Advisor) for the Bureau. The Advisor will serve as a liaison between the Bureau and interested youth, young adults, families and community agencies. Her work will support the development of priority needs of parents, ensure the Bureau understand issues of interest to parents and communicating concerns and success across the state.

The Special Kids Network System of Care (SKN SOC) has assumed responsibility for the coordination of the Parent Youth Professional Forums (PYPFs) effective June 1, 2011 under a no-cost extension from the State Implementation Grant and MCH Block Grant funding. In October 2011, statewide PYPF representatives met with leaders from the Bureau of Family Health (BFH) to voice the recommendations and priorities that had been gathered from discussions within the Forums. A Core Leadership Team was developed at a statewide level to provide a more formal and consistent mechanism for sustaining the efforts. This team consists of parents, youth and professionals from each district as well as Department of Health representatives from the BFH. The Core Team held regular meetings via phone and web-ex (internet based meetings), and worked collectively to develop a 'work plan' to provide information and direction for action on the priority recommendations provided through the PYPFs. In an effort to maximize family participation in decision making, families provided an analysis of call center operations from their perspective and then assisted in the development of a 3-day call center staff training to enhance staffs skills in responding to families seeking information and resources. Parents were also engaged in reviewing draft outreach resource materials for clarity of content and ease of use before those materials were produced.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Established the Parent Youth Professional Forum (PYPF) concept to enhance communication to and from families to the Department. | | X | | |
| 2. Established Core Team of PYPF participants from each of the Department's six health districts to strategically address priority issues defined by parents and youth. | | | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

PA-TSA will continue to provide advocacy and public awareness services, including outreach to underserved populations. Trained volunteers are increasing awareness by being visible at a greater number of local events.

MH Program practices continue to engage 142 Parent Partners representing 32 practices across the state. Surveys indicate families are partners in their child's care (88.0%) and care coordination is always or usually helpful (80.0%).

To ensure consistency, the Advisor and DOH staff developed templates to be utilized statewide regarding events, announcements, save the date, minutes, and agenda's of all the PYPFs. This

uniform look brands the PYPF's for those who want to be updated and involved.

WebEx technology is being utilized to address parents' concerns about long distance travel and meetings at additional locations such as schools and public libraries are being explored. The PYPFs will continue to focus the work of the BFH and the Core Team on DOH priorities, and share cross agency issues to assist in resolution. SKN SOC will regularly consult the Bureau's parent advisor on program decisions affecting families and CYSHCN.

Diverse populations continue to be engaged through communications with cultural brokers and the holding of informal 'family gatherings,' with the intent of increasing diverse presence at the PYPFs. Special attention is being given to ensuring that sustainable relationships are created and that diversity in the PYPFs continues to grow.

**c. Plan for the Coming Year**

The MH Program will continue to identify practices without Parent Partners and provide technical assistance on the recruitment and retention of parents. The Parent Advisor will continue to work to increase the involvement of parents, families, youth/young adults, and community agencies with the PYPF's and the DOH to support consistency and communication between all.

The development of parent, youth, and agency communication is an ongoing process that requires consistent improvement by the Advisor. The role of the Advisor has provided the Bureau with the voice of the parent, children with special health care needs and especially the voice of those who are unable to speak for themselves.

Through the participation of parents and youth on the Core Team, opportunities will be made for review of the Special Kids Network System of Care web portal for content, search features, forum workgroup communication and other related technology that will provide easier access and greater satisfaction with the services received by families of CYSHCN. The Core Team can assist the Special Kids Network System of Care with opportunities for PYPF participants to review and test the web portal additions prior to launch for ease of use of this technology. We intend to institutionalize our efforts to engage parents and youth in guiding the work of the Special Kids Network System of Care through all components of the program including our Statewide Initiatives, Community Systems Development, Community Mapping and SKN SOC Helpline. The SKN SOC will continue to facilitate leadership training opportunities for the parents and youth who are involved with the PYPFs.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 54 | 54 | 45.8 | 45.8 | 45.8 |
| Annual Indicator | 45.8 | 45.8 | 45.8 | 45.8 | 48 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | See field level note | See field level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 48 | 48 | 48 | 48 | 48 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

**Notes - 2009**
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

**a. Last Year's Accomplishments**
In 2011 calendar year, 864,736 children and youth had access to a medical home in 47 out of 67 counties in Pennsylvania. These individuals received care in a pediatric practice trained in medical home principles.

To date, 142 primary care practices have been trained in medical home principles through the Pennsylvania Medical Home Program (MH Program) through the efforts of the PA Chapter of the American Academy of Pediatrics. Emphasis in Pennsylvania is specifically on establishing medical homes for children and youth with special health care needs (CYSHCN). Over 24,377 CYSHCN, in 64 practices, have been identified using patient registries. The registry enables practices to better coordinate each patient's care by providing alerts regarding the need for appointments, immunizations, well child visits, identifying patients overdue for checkups and/or treatment.

To date, a total of 39 practices have received funding for care coordination, a service often desired by families. Multiple benefits have resulted from the development of care coordination including sharing information about local resources with parents, improved efficiency in the management of this population within the practice, better communication with specialist that treat

CYSHCN by utilization of shared care plans, increased continuity of care via care plan when the CYSHCN needs to visit the emergency department and enhanced understanding of a child or families need for community partners and service providers in the provision of useful and necessary information for schools. Additionally, The Elks Home Service Program continued to be funded to provide community based care coordination in conjunction with medical home practices. Practices refer to the Elks when a situation arises with a patient that could benefit from a more intensive amount of support such as home evaluation for equipment needs and support around transition to adult health care.

A total of 129 parents/caregivers have participated in their medical homes as parent partners in 2011. A parent partner is a parent or caregiver of a child or youth with special health care needs who agrees to serve on the practice's medical home team and offer guidance based on their personal experience to help the practice achieve family-centered care. All active practices in the MH Program are receiving yearly Practice Reports to evaluate their work and set new goals for the coming year. The Report focuses on the patient registry, medical home index scores, family medical home survey results, and a summary of an intensive care coordination study.

Two quality improvement conferences were hosted for medical home practice teams, families, state agency staff, and community partners. A total of 230 individuals benefited from presentations focusing on Epilepsy and Early Hearing Detection and Screening.

The medical home website was renamed "Especially for Parents, Caregivers & Youth" to reflect the expanded interest and focus of the site. This is an online network and forum where parents of children and youth with special health care needs currently host 19 discussions focusing on issues that include autism, cerebral palsy, and transition. Four of these forums are held in Spanish. As of December 2011, the site had 400 members representing parents, health professionals, government agencies and nonprofit entities. Additionally, the PAMHP has increased its presence on the web by creating a Facebook fan page.

The efforts of the PA medical home program and other partners have resulted in several policy changes reflecting the voices of families and practices across Pennsylvania: 1) after identifying central and essential elements to be included in care plans for practice teams to garner reimbursement, Medicaid in PA reimburses for care plan development and oversight in Fee for Service Counties; 2) understanding that children with complex diseases often require more time with physicians, an increased fee schedule now allows physicians to acquire increased reimbursement for caring for more complex children in their care.

The Bureau, in an effort to address youth transitioning to adult healthcare, is supporting the development of adult medical home practices that can interface with the existing pediatric practices in order to provide age-appropriate services to young adults with disabilities as they leave the pediatric system and advance to independent living. See SPM 9 for additional details.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Enhanced the Especially for Parents, Caregivers and Youth Website for a broader audience. | | X | | |
| 2. Collaborated and worked toward policy change so as to effect change in fee reimbursement for providers (IB). | | X | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

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|---|---|---|---|---|
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The MH Program is collaborating with a hospital system to expand the number of pediatric medical home practices in the south central region with the intent that all the system's pediatric practices become active medical homes.

Three additional practices are receiving support for care coordination activities.

Training continues via on site and teleconferences. The spring conference focused on asthma and the fall conference will focus on dental care. Three practice wide conference calls focused on medical assistance transition related policy; resources created by parents for parents of children with hearing loss; and improving concussion care for children.

The MH Program has also been engaged in furthering practice knowledge on youth transitioning into adult healthcare settings (see SPM 9 for more details).

The Chronic Care Initiative is again working with insurers and practitioners to implement better chronic disease care. Although primarily focused on adult patients, a small subgroup of pediatricians is focusing on asthma management in children. The Director has approached the Bureau about collaboration with the MH Program.

**c. Plan for the Coming Year**
The MH Program will continue to move forward with implementation, including the expansion of the number of children receiving care in a medical home and continuing recruitment of potential practices.

The Medical Home Advisory Committee made some recommendations on expanding the website and Facebook pages and recommended discussions around the adoption of electronic medical health records among other topics of interest like autism spectrum disorders.

The Grantee for the MH Program is also involved in a number of grant opportunities, focusing on mental health and dental health that will ultimately benefit the children with the medical homes in Pennsylvania.

The work around the transition of youth to adult medical home practices will also continue, see SPM 9 for more details.

The MH Program grant agreement was extended for two additional years through June 30, 2014.

Some collaborative relationship with the CCI is expected but how that will develop is yet to be seen.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Annual Performance Objective | 70 | 70 | 66.2 | 66.2 | 66.2 |
| Annual Indicator | 66.2 | 66.2 | 66.2 | 66.2 | 69 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | See field Level note | See field Level note | See field Level note | See field Level note |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 69 | 69 | 69 | 69 | 69 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN). The performance objective will remain at that level until indicators based on the next survey are available.

**Notes - 2009**
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

**a. Last Year's Accomplishments**
In Pennsylvania, 17.0% (469,906) of children ages 0 -- 17 years have a special health care need. Of those identified with a special health care need, 93.2% were covered by private or public insurance, above the National average of 90.7%.

The Data Resource Center for Child and Adolescent Health reports that 6.8% of children with special health care needs in Pennsylvania were without health insurance at some point. This number decreased by 0.8% from 2005/2006 (7.6%) and -3.1% from 2001.

The Health Care Handshake Agreement, combined with The Cover All Kids initiative, continued to ease the enrollment process for the state's Children's Health Insurance Program or CHIP and Medical Assistance (MA) programs. In 2009, the Handshake Agreement was initiated to provide an electronic means of delivery and exchange of CHIP and MA applications between the Pennsylvania Insurance Department (PID) and the Department of Public Welfare (DPW). This Handshake Agreement significantly improved successful completion of the eligibility determination and application process, thus resulting in more children having adequate insurance for their needs. For calendar year 2011, average MA enrollment increased by 2.3% (1,137,811) over the previous calendar year (1,111,941); average CHIP enrollment remained steady at 194,268.

In 2011, the Health and Human Services Call Center (HHSCC) added over 200 Pennsylvania Community Health Center Federally-Qualified Health Centers (FQHCs) to the resource database. Some FQHCs are "Look-Alike" programs meeting all statutory requirements under the oversight of the Health Resources and Services Administration (HRSA). In March 2011, the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) provided policy clarification on the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and the Affordable Care Act of 2010 (ACA); states may not prevent FQHCs from entering into contractual relationships with private dental providers. This removes potential barriers to MA or CHIP coverage for dental services. In March 2011, CMS also announced ACA policy clarification that MA can provide coverage for freestanding birth center services and certain professional services provided in a freestanding birth center; States will submit amendments to their Medicaid State Plans.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Contracted with multi-disciplinary specialty clinics to explore insurance products and identify the most appropriate product that will provide the greatest financial relief for children and adults served by the specialty clinics. | X | X | | X |
| 2. Provided information and referral services to screen and refer CYSHCN and their families for health care coverage. | | X | | X |
| 3. Conducted Medical Home training of pediatric practices. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The Health and Human Services Call Center (HHSCC) helpline Specialists continue to employ discovery questions with callers to determine if their children have health care coverage, specifically if any child in the household has a special health care need. The family is prescreened for eligibility under Medical Assistance (MA) or Children's Health Insurance Program (CHIP). When a child is identified as having a special healthcare need, they may be referred to Social Security, the County Assistance Office, and/or the Department of Health's Special Needs Unit.

During calendar year 2011, 687 Medical Assistance (MA) Applications were disseminated to

helpline callers with a special need; 181 callers were referred to the local Social Security (SS) Office; 243 callers were referred to the Department of Health Special Needs Unit (SN); and 789 individuals were referred to the local County Assistance Office (CAO).

To date, over 870 families and professionals access information on the Health and Human Services Call Center (HHSCC) HelpinPA Facebook page. The Departments of Health, Aging, Public Welfare and the Pennsylvania Insurance Department develop the content, which is posted to the Facebook page by the HHSCC. Postings include program related information, insurance updates, health related articles and community-based events specific to the special needs population.

**c. Plan for the Coming Year**

Services (I&RS) Section is coordinating efforts to identify resources to complete a current, comprehensive statewide assessment of Bureau programs that serve children with special health care needs ages 0-18. The intent of this initiative is to establish statewide, county-level baseline data and analysis of key indicators of performance that ensure families of CYSHCN have easy access to comprehensive information about services and programs.

Based on the results of the assessment, healthcare disparities for children and youth with special health care needs will be addressed by partnering with sister State agencies, specifically, the Pennsylvania Insurance Department and the Department of Public Welfare, entities at the community level and parents of children with special health care needs.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 82 | 89.5 | 89.5 | 89.5 | 89.5 |
| Annual Indicator | 89.5 | 89.5 | 89.5 | 89.5 | 69.4 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | See field Level note | See field Level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 69.4 | 69.4 | 69.4 | 69.4 | 69.4 |

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001

CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

**Notes - 2009**
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

**a. Last Year's Accomplishments**
The PA Medical Home Program is working with Family Voices to expand and enhance family centered care in the medical home practices. Some examples of this work include the development of care plans for children and youth with special health care needs (including the child's strengths as a positive indicator) and pre visit calls.

The Family Health Nursing Services Consultants (FHNSC) worked with their community partners to map ten additional communities and update previously mapped communities in the SKN SOC Web Portal. Community Partners, the BFH Parent Advisor, and parents, youth and professionals of the PYPFs play a larger role in providing community assets and resources to the mapping process and continue to advise on how community based service systems are organized so that they are accessible for the ease of use for families of CYSHCN.

The SKN SOC Statewide Initiatives of Transition, Inclusion, Transportation and Respite have continued to provide opportunities for community and cross agency involvement. The Community of Practice on Transition State Leadership Team, through efforts of the Department, has created transition products for Pennsylvania that will provide information to families to prompt them to discuss earlier transition planning for their youth/young adults with special health care needs. These transition products will be disseminated through all agencies that participate on the Transition State Leadership Team so that parents of children and youth with special health care needs are prepared to begin the discussion of transition to adult life early.

SKN SOC participated with the Special Quest State Leadership Team on Early Childhood Inclusion, delivering a presentation of the SKN SOC Initiatives, and the SOC engaged with other organizations such as the Pennsylvania Premature Infant Health Network and the Elks Home Service program (service coordination).

The FHNSCs in the Northwest region continued to collaborate on a Special Needs Inclusion Project with a Faith-Based Community. The Venango County Profiles in 2010 showed that 49.7% of students are eligible for free and reduced school lunches, evidencing a greater need in 2011 than when first identified in 2008. Another initiative provides young ladies in Venango, Forest,

Crawford, Butler, Mercer, Warren, and Clarion County High Schools, including those with special needs, gently used prom dresses. With faith-based and community support, there was an increase in the number of dresses and accessories were donated this year to support this initiative. One hundred and twenty six (126) young ladies in these high poverty areas were given the opportunity to attend their prom in the last five years.

Through the Transportation Initiative, the opportunity continued for cross agency collaboration with the introduction of the Individual Transportation Plan (ITP) for CYSHCN in local school districts. The ITP was developed by the Easter Seals of Western Pennsylvania. With input from the Departments of Health, Education, Transportation and community organizations such as the Injury Prevention Program at Hershey Medical Center, a curriculum was developed to train school and transportation personnel on the importance of planning for safe transportation of CYSHCN. The ITP assists school administration, bus drivers, and parents to identify the child's needs during transportation to and from school. Training began on the implementation of ITP with school and bus personnel in the fall of 2011. The Division of School Health disseminated the ITP to Pennsylvania's 500 districts.

An interagency team including the Departments of Aging, Health, and Public Welfare along with the Pennsylvania Coalition for Respite Care formed the Lifespan Respite Care Advisory Council. Through the Lifespan Respite Care Grant, the Council was able to award three five-thousand dollar grants to existing respite care agencies to expand respite services for families during an unforeseen emergency and to those with unmet needs. The Council has enhanced the ARCH National Respite Locator with Pennsylvania respite care providers and continues to identify respite care providers that are included on the Department of Aging website as well as in the SKN SOC resource database.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Conducted Medical Home training of pediatric practices. | | | | X |
| 2. Worked within the community to assure services are delivered in a manner that is accessible to families in need of them. | | | | X |
| 3. Contracted with local health departments to provide information and referral on available community resources and link families to appropriate settings. | X | X | X | X |
| 4. Contracted with multi-disciplinary specialty clinics to insure case management and care coordination for children and adults served by the specialty clinics. | | X | | X |
| 5. Community mapping initiative enhanced information on service provision within communities and made the resulting information available to families. | | X | | X |
| 6. Subcontracted with the Elks Home Service Program to assist families with service coordination needs from families' home environment. | | X | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The Epilepsy Program is focusing on educating school health nurses to assist children with epilepsy within the school setting. Training was provided at the Pennsylvania School Health Nurse Conference and web based training is being developed. Additionally, training for

emergency responders is also taking place.

The SKN SOC continues to make information about its scope of services available through continued involvement on interagency and inter-organization committees such as the PA Premature Infant Health Network, the Head Start Oral Health Task Force, the PA CARES TASK Force, and the State Leadership Team on Transition. The SKN SOC actively seeks opportunities to build a network of organizations that will continue, through collaboration, to improve the ease of use and access to resources for CYSHCN. Work continues with the Elks Home Service Program Care Coordination project. The SKN SOC receives monthly reports which include the identification of barriers families encounter in obtaining services for their CYSHCN. As the barriers are identified and compiled, the reports are shared internally and with the PYPF with the intent of determining the best method for arriving at a solution. The PYPFs and the PYPF Core Leadership Team continue to inform and guide the work of the SKN SOC. This work will further be defined with input from the addition of the Parent Advisor to the Bureau of Family Health.

**c. Plan for the Coming Year**

The SKN SOC will continue to seek the advice and guidance from the PYPFs, PYPF Core Leadership Team and the Parent Advisor to ensure that program resources are used to achieve the desired and applicable national and state performance measures as well as the six identified PYPF priorities.

The SKN SOC will continue to identify and improve on technologies that will enable parents, CYSHCN, and those organizations serving them to more easily access and use community-based services. SKN SOC intends to improve its website to include a robust, intuitive searchable resource database, a feature to allow communication between participants of the six regional PYPFs, and other relevant features requested by PYPF participants.

Efforts will continue to create awareness of the scope of service of the SKN SOC through greater involvement of PYPF participants, through the evolving network of community-based organizations and through inter-agency relationships.

The SKN SOC will expand the work being performed by the Elks Home Services program through its contract with the PA AAP. The current Elks Care Coordination Manager position will be responsible for responding to calls from the SKN SOC helpline. Calls will be triaged with callers being provided a range of services from information and access to resources to a referral to an Elks Home Service staff person who would work with the caller in their home environment to obtain services. The addition of a Community Systems Development component will also be included. Six positions, one each in the district health regions would be hired. A primary criterion for the position is that it is filled with a parent who has or had a child with a special health care need.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Annual Performance Objective | 38 | 48 | 46 | 46 | 46 |
| Annual Indicator | 46 | 46 | 46 | 46 | 40 |
| Numerator | | | | | |
| Denominator | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Data Source | | See field level note | See field level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 40 | 40 | 40 | 40 | 40 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

**Notes - 2009**
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

**a. Last Year's Accomplishments**
To address the medical aspect of youth with special health care needs transitioning from pediatric to adult healthcare, DOH applied for and was awarded a federal grant, 'Innovative Evidence Based Models for Improving the System of Services for CYSHCN' from the Health Resources and Services Administration to focus on the transition process within the Pennsylvania Medical Home Program (MH Program). The work that began in October 2011 focuses on expanding and replicating existing transition efforts forged under the previous State Implementation Grant; creation of a Transition Advisory Committee comprised of practices, youth, parents and government and community agencies; creation of a transition care coordination learning module for future expansion of efforts; and collaborating with the Pennsylvania Chapter of the American College of Physicians to engage adult clinicians in transition efforts. Activities under this grant

compliment the work addressing Pennsylvania's State Priority 9 regarding transition.

The Pennsylvania Transition State Leadership Team (SLT) Department representatives continue to collaborate in supporting youths with special health care needs in becoming productive, participating, healthy citizens. Michelle Connors, Director of the Division of Community Systems Development and Outreach participated in an interview of Commonwealth department officials who spoke to the importance of transition to adulthood. The BFH supports transition activities to ensure that support for youth in transition to adult life is a matter of highest priority.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Participated in the annual PA Community of Transition Conference planning and provided health related sessions for youth with special health care needs and their families. | | X | | X |
| 2. Participated in MOU Shared Agenda on Transition to create pathways to adulthood for YSHCN in all aspects of adult life: health, education, employment, and housing. | | X | X | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

SKN SOC provides resources for the 2012 Pennsylvania Community on Transition Conference: Empowerment in an Environment of Change. Transition products have been developed for Pennsylvania families to prompt early planning for transition into adulthood. These products will be disseminated through all the partner agencies on the Team on Transition to insure that families plan early for transition.

The MH Program is creating four practice dyads focusing on the transition process for youth and for the practices as the youth move to adult health care. This work is a continuation of work under a previous grant. The National Center for Cultural Competence will be providing training to medical home dyads on cultural competence. They will also provide support to the medical home program by helping link to culturally and linguistically appropriate resources for the youth and their families. See SPM 9 for further details.

**c. Plan for the Coming Year**

SKN SOC staff that participates in the Community of Practice on Transition State Leadership Team will join members of the Community of Practice on Behavioral Health to form the RENEW PA State Advisory Team to assist youth with behavioral and emotional challenges in school, home and community. RENEW (Rehabilitation for Empowerment, Natural supports, Education, and Work) is a structured facilitated planning and support process for youth who are struggling in school, at home, and in their communities.

The Core Leadership Team of the Parent Youth Professional Forums will continue the development of relationships with youth who have participated in the Youth Leadership

Development Institutes to insure that the youth and young adult voice is being acknowledged and that the activities are youth focused and youth driven.

The MH Program will continue to expand their work on transitioning youth into adult health care through various activities that will include: identification of appropriate adult primary health care providers; education of the adult primary care providers, creation of additional practice dyads; identification of community resources and continuing collaboration with family and youth support organizations. See SPM 9 for further details.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 87 | 85 | 85 | 80 | 80 |
| Annual Indicator | 81.4 | 80.4 | 71.8 | 81 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | See field level note | See field level note | See field level note | |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 80 | 80 | 80 | 80 | 80 |

**Notes - 2011**
Data for 2011 will not be available until later in the year 2012.

**Notes - 2010**
2010: 81.0±4.3
4:3:1:3:3 series coverage it is not recommended for comparison to years prior to 2009 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples.

**Notes - 2009**
The Annual Indicators were obtained from the National Immunization Survey conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. Data are for children 19-35 months of age. Numerators and denominators are not available.

Data in this form:
2006: 84.6+4.4
2007: 81.4+4.1
2008: 80.4+4.9
2009: 71.8+5.8

Future objectives will remain as stated. Since 2006, based on the variance in the immunization rate, 80 has been determined to be the appropriate objective until the fluctuation stabilizes.

**a. Last Year's Accomplishments**

According to the National Immunization Survey (NIS) for 2010, 78.8% of 19 to 35 months old in Pennsylvania received 4 doses of a DTP vaccine, 3 doses of polio vaccine, 1 dose of measles/mumps/rubella vaccine, 3 doses of haemophilus influenzae type B vaccine, 3 doses of hepatitis B vaccine and 1 dose of varicella vaccine (4:3:1:3:3:1). The annual performance objective of 80% cannot be utilized because the 2010 NIS data now includes varicella vaccine and National Performance 7 does not include varicella vaccine. Therefore, NIS data for 2010 cannot be adequately compared to previous years.

Pennsylvania witnessed an increase in coverage from 69.0 % in 2009 to 78.8% in 2010 for the 4:3:1:3:3:1 series.

The main focus of the Division of Immunization is to eliminate or control vaccine-preventable diseases. Vaccines are provided to public and private health care providers for infants, children, adolescents and adults to protect against diseases such as measles, diphtheria, tetanus, pertussis (whooping cough), polio, mumps, rubella (german measles), hepatitis A, hepatitis B, influenza, haemophilus influenzae type b, pneumonia, varicella (chickenpox), meningococcal, human papilloma virus and rotavirus.

A hospital based hepatitis B birth dose program, Tot Trax, currently has 95 out of 95 birthing hospitals throughout the Commonwealth participating in the program. Of those participating, 99% utilized Department supplied hepatitis B vaccine to immunize their newborn prior to discharge.

The Division of Immunizations continues to offer opportunities for Pennsylvania school-aged children to obtain the required immunizations during school-based clinics. Schools had the opportunity to offer hepatitis B, tetanus/diphtheria acellular pertussis (Tdap), meningococcal (MCV4) and varicella vaccines to school based clinics for the 2010-2011 school year.

Annually, each public and private school in Pennsylvania is required to report the immunization status of their students. The report is antigen specific and only for kindergarten and seventh grades for both public and private schools for the 2010-2011 school year. 7.43% were provisionally enrolled, a decrease from 8.18% in 2009 and 0.43% were medically exempt, a decrease from 0.84% in 2009, and 1.42% claimed religious exemption, a decrease from 1.73% in 2009.

Annually, Childcare Group Settings are required to report immunization histories for children in their facilities. This requirement coincides with and assists the Department of Public Welfare's requirement to ensure that children in these facilities are appropriately immunized and protected against vaccine preventable diseases.

In 2010 approximately 5,140 childcare group settings were required to report immunization histories for the children attending their facilities. Compared to 2009 data of 4,105 childcare group settings were required to report immunization histories which represents a 25.0% increase in child care groups settings required to report.

The Pennsylvania's Statewide Immunization Information System (SIIS) is a vehicle for monitoring, tracking and accounting for more than 2 million doses of vaccines on an annual basis among approximately 1,600 provider sites. The statewide Pennsylvania Immunization Coalition (PAIC) and the network of county and regional coalitions actively promoted, strengthened and expanded immunizations in Pennsylvania. There are 18 local coalitions across the state, covering 46 counties.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Immunization vaccines, support and training are provided to the public. | X | | X | |
| 2. Vaccines support and training are provided via the VFC program to infants and children. | X | | X | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

National Infant Immunization Week (NIIW) held April 21st to 28th highlighted the importance of protecting infants from vaccine-preventable diseases and celebrated the achievements of immunization programs in promoting healthy communities throughout the United States. During the month of April 2012, the Division of Immunization made available on the Department of Health website the National Infant Immunization Week tool-kit for healthcare provider use as well as making it available to all Department District Offices and County Municipal Health Departments. Outreach activities for minority, disparate, or underserved children were encouraged for the purpose of positively impacting families, healthcare providers, and public health officials to increase immunizations.

During the month of April 2011, the Pennsylvania Vaccines for Children (PA VFC) Program conducted a medical provider satisfaction survey of its approximate 1,600 public and private healthcare provider clinics enrolled in the PA VFC Program. Measuring program satisfaction of enrolled PA VFC Providers offered another indicator of the PA VFC Program's progress toward achieving its goal of providing maximum immunization coverage to VFC-eligible children and eliminating the occurrence of vaccine preventable diseases in Pennsylvania. The survey asked a total of 43 questions and overall, 98% of providers indicated they agreed or strongly agreed that they were satisfied with the PA VFC program.

**c. Plan for the Coming Year**

Throughout 2011 CDC expanded using the Vaccine Tracking System known as VTrckS, an information technology system that will integrate the entire publicly-funded vaccine supply chain from purchasing and ordering to distribution of the vaccine, from four pilot grantees to six. This year was an educational year involving a number of conference calls educating grantees on the progress the six grantees were making and preparing grantees for the transitions to online ordering. At the same time grantees were deciding which mechanism to choose for the online ordering. There were two choices available; one option having providers log into the VTrckS system directly to place online orders or the second option grantees choosing to use their registry as the venue for online ordering. Pennsylvania decided to use the registry for this process. In the latter part of 2011 the Spend Plan piece for all grantees was transitioned from the Vaccine Online Forecast Application (VOFA) to VTrckS. Training for this transition will take place in 2012. In addition Pennsylvania was informed that February 2013 is the official launch date that online vaccine ordering will be available to the state.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Annual Performance Objective | 12 | 15.3 | 15.1 | 14.9 | 14.5 |
| Annual Indicator | 16.1 | 16.3 | 14.5 | 14.2 | |
| Numerator | 4313 | 4269 | 3862 | 3562 | |
| Denominator | 267102 | 262295 | 265979 | 251182 | |
| Data Source | | See field level note | See field level note | See field level note | |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 14.4 | 14.4 | 14.3 | 14.3 | 14.2 |

**Notes - 2011**
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2010**
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: U.S. Census Bureau

**Notes - 2009**
Numerator source:
PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

**a. Last Year's Accomplishments**
The Division of Child and Adult Health Services (DCAHS) worked with the preconception health team, made up of individuals from the Pennsylvania Department of Education, the Center for Schools and Communities, and the Family Health Council of Central Pennsylvania, Inc., to finalize the adolescent life planning tool, the "Teen Game Plan." The "Teen Game Plan" is designed to make teens think about how the decisions they make now impact their future and their ability to reach their goals. The "Teen Game Plan" was made available on the Department of Health website.

For additional activities please see State Performance Measure 4.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Served as a board member on the Pennsylvania Coalition to Prevent Teen Pregnancy. | | | | X |

| | | | | |
|---|---|---|---|---|
| 2. Maintained and updated the SAFETEENS website. | | | X | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The DCAHS is partnering with the Family Health Council of Central Pennsylvania (FHCCP) and Maternal and Family Health Services (MFHS) to utilize the "Teen Game Plan." The FHCCP will utilize the "Teen Game Plan" to deliver counseling, education, referral and follow-up with pregnant or parenting youth under the age of 22 receiving WIC services in Cumberland County and with youth participating in FHCCP education programs in Somerset County. MFHS will develop a curriculum around the "Teen Game Plan" to use during Teen Time at MFHS clinics, and will incorporate it into their Reduce the Occurrence of Subsequent Pregnancies Project. MFHS will also deliver the evidence-based Making Proud Choices curriculum to approximately 300 youth.

For additional activities see State Performance Measure 4.

**c. Plan for the Coming Year**
The Division of Child and Adult Health Services will continue to utilize the Teen Game Plan as described above and will continue to fund MFHS to deliver the Making Proud Choices curriculum.

For additional activities see State Performance Measure 4.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 38 | 30 | 26 | 27 | 27.5 |
| Annual Indicator | 25.8 | 25.8 | 28.6 | 32.0 | 33.2 |
| Numerator | 15248 | 15248 | 17984 | 20853 | 23017 |
| Denominator | 59114 | 59114 | 62815 | 65259 | 69329 |
| Data Source | | See field level note | See field level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |

| Is the Data Provisional or Final? | | | | Final | Final |
|---|---|---|---|---|---|
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 27.5 | 28 | 28 | 28 | 28 |

**Notes - 2011**
Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/11 who have a protective sealant on at least one permanent molar tooth, based on paid dental claims. The denominator is the number of Medicaid enrollees who are 8 years old as of 09/30/11.
Source: PA Department of Public Welfare

**Notes - 2010**
Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/10 who have a protective sealant on at least one permanent molar tooth, based on paid dental claims. The denominator is the number of Medicaid enrollees who are 8 years old as of 09/30/10.

Source: PA Department of Public Welfare

Future objectives will remain as stated. Although there was a spike in 2010, there is not sufficient data to determine what caused the upward shift.

**Notes - 2009**
Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/09 who have a protective sealant on at least one permanent molar tooth, based on paid dental claims. The denominator is the number of Medicaid enrollees who are 8 years old as of 09/30/09.
Source: PA Department of Public Welfare

**a. Last Year's Accomplishments**
Dental sealants are a covered dental benefit for children under the PA Medical Assistance Program, similar to Medicaid Programs in other states. Since 2006, Pennsylvania has seen some proliferation of provider groups who focus practice outreach in community and school-based settings, using mobile/portable equipment. They concentrate on delivery of diagnostic and preventive services, including dental sealants. Additionally, since early 2009, the Office of Medical Assistance Programs has implemented a Dental Disease Management (DDM) Program in primarily rural counties. Under the ACCESS Plus Program, operating in 42 counties in the Central and Northern tier areas of the State, dentists are invited to enroll in the DDM Program. They are encouraged to provide a "dental home" to identified cohorts of Medicaid recipients for which they receive pay-for-performance (P4P) incentive payments when selected oral health services are delivered. OMAP has observed an increase in diagnostic and preventive services, including dental sealants, for children enrolled in ACCESS Plus since implementation of the DDM P4P Program.

The goal of Healthy People 2020 Objective 12.2 is to Increase the proportion of children aged 6 to 9 years who have received dental sealants on one or more of their permanent first molar teeth to 28.1%. The goal of Healthy People 2020 Objective 12.3 is to increase the proportion of adolescents aged 13 to 15 years who have received dental sealants on one or more of their permanent molar teeth to 21.9%. The Department's Oral Health Needs Assessment (OHNA 2000) found that approximately 25.0% of 8 and 14 year olds in Pennsylvania have at least one dental sealant. Since state fiscal year 2006-2007, the Department funded 3 school-based dental sealant programs at the Allegheny County Department of Health, Chester County Health Department, and the York City Department of Health to expand the availability and accessibility of this important preventive oral health measure. Program efforts provided funding to acquire appropriate equipment and organize outreach at schools with at least 50.0% enrollment of students in the Free and Reduced Cost School Meal Program. To date, a total of 25,507 sealants have been applied to 8 and 12 year molars in 6,232 children. In addition, preventive education, including information on drinking soda, was presented to all children.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Funded 3 school-based dental sealant programs to expand the availability and accessibility of oral health. | X | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
In state fiscal year 2011-2012, funding for the school-based dental sealant programs has been continued to the 3 grantees. Approximately 2,010 students are expected to participate. In addition, the Department will continue to utilize the Sealant Efficiency Assessment for Locals and States (SEALS) data collection program.

**c. Plan for the Coming Year**
Pending available funds, the Department will continue the school-based dental sealant programs in state fiscal year 2012-2013. It is estimated that grantees will maintain a level of 1,725 students participating.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Annual Performance Objective | 2.3 | 2.3 | 2.3 | 2.3 | 1.9 |
| Annual Indicator | 2.2 | 1.4 | 1.7 | 1.8 | |
| Numerator | 50 | 32 | 40 | 41 | |
| Denominator | 2299158 | 2290858 | 2309944 | 2274324 | |
| Data Source | | See field level note | See field level note | See field level note | |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 1.8 | 1.7 | 1.6 | 1.5 | 1.5 |

**Notes - 2011**
Data Not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2010**
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: U.S. Census Bureau

**Notes - 2009**
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

Future Annual Performance Objectives were adjusted.

**a. Last Year's Accomplishments**
Numerous organizations (e.g. Safe Kids Pennsylvania, the American Trauma Society - PA Division) conducted various child passenger safety events throughout Pennsylvania each year. At these events, child safety seats are checked for proper fit and installation by certified child passenger safety technicians. Educational materials are provided and a dialogue is established with each caregiver. In addition, the Department's Violence and Injury Prevention Program received a five-year grant from the CDC to develop, implement, and evaluate strategies to promote motor vehicle safety among children.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Conducted infant safety seat events checks. | | | X | |
| 2. Conducted child passenger safety technician courses and refresher courses. | | | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The Department facilitates an Injury Community Planning Group (ICPG) consisting of injury professionals throughout the state. The ICPG Motor Vehicle Safety workgroup is tasked with identifying intervention opportunities and targeting motor vehicle safety issues that are represented in Pennsylvania.

The Department has developed a partnership and an agreement with the Department of Transportation to address youth motor vehicle deaths and injuries and to develop a more efficient means to share data.

**c. Plan for the Coming Year**
The Department will be publishing an action plan to address childhood motor vehicle safety as part of a Statewide Injury Prevention and Control Plan for 2012-2016.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Annual Performance Objective | 40 | 40 | 37.5 | 37.5 | 37.5 |
| Annual Indicator | 36.2 | | | | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | See field level note | See field level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 37.5 | 37.5 | 37.5 | 37.5 | 37.5 |

**Notes - 2011**
2008 birth data should become available in 2011/2012. Data delay as CDC is developing a new system of data collection by year of birth. These data are collected over a 3-yr period and final data are available 4 yrs from date of birth. Notes-2011 No new data is available.

**Notes - 2010**
Data delay as CDC is developing a new system of data collection by year of birth. These data are collected over a 3-year period and final data are available 4 years from date of birth.

**Notes - 2009**
Data delay as CDC is developing a new system of data collection by year of birth. These data are collected over a 3-year period and final data are available 4 years from date of birth.

**a. Last Year's Accomplishments**
Due to a significant increase in USDA funding, four more local WIC agencies implemented a breastfeeding Peer Counselor Program and the six agencies with established Peer Counselor Programs were able to expand services. The breastfeeding training protocols for WIC staff developed during the previous year were implemented statewide.

Effective July 1, 2011, small grants were awarded to eleven birthing hospitals and birthing centers in Pennsylvania for activities to increase their breastfeeding initiation and duration rates. Activities ranged from translation of breastfeeding educational materials to providing breast pumps for mothers of infants in intensive care to staff education and training. Grants are for a one-year period and terminate June 30, 2012. Information about the grants and lessons learned from the grantees will be shared with the breastfeeding community in the state.

After two years of being vacant, the position of Coordinator of the Pennsylvania Breastfeeding Awareness and Support Program was filled by an International Board Certified Lactation Consultant in October 2011.

DOH's breastfeeding website was updated and included 2009 data regarding initiation rates,

county based data and data regarding diverse populations. Updates to the 2007 PA Breastfeeding Referral Guide were also started. An undergraduate Nutrition student from Penn State spent a two week internship identifying web based resources for parents to expand the program's offering of resources in response to a variety of consumer requests.

Approval was obtained to fund the EPIC BEST program effective July 1, 2012. EPIC BEST (Educating Practices in their Communities Breastfeeding Education Support and Training) is a program where a physician and a lactation consultant team provides a one-hour in-service program on breastfeeding for physicians and office staff at the practice site with the goal of increasing breastfeeding initiation and duration rates. The program will operate for two years and it is estimated that a minimum of 110 programs will be presented.

The Bureau's four Maternal Child Health Nurse Consultants supported the breastfeeding program by providing seven Happiest Baby presentations, approaching eight businesses about establishing employee lactation rooms and working with sixteen Breastfeeding Coalitions.

WIC (Women, Infants and Children) received $822,739 as a federal bonus for improving breastfeeding rates among mothers enrolled in the program. Plans were developed to grant the funds to six hospitals in Philadelphia as well as three in rural areas.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Conducted WIC annual training of all new professionals on breastfeeding support techniques and resolution of problems. | | | | X |
| 2. Developed and distributed public education resources. | | | | X |
| 3. Promote breastfeeding and support practices through presentations at hospitals, physician offices, and other public places. | | | | X |
| 4. Evaluating data based on a geographic focus to assess where activities/intervention is necessary. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

PA WIC received a breastfeeding bonus award from USDA for $822,739 for being one of the states with the most improvement in initiation rates nationally. Factors contributing to this success, include changes to the WIC food packages, increased peer counseling and revised training activities over the past two years. Bonus funds are being used to reward a high performing local agency as well as assist several struggling agencies to improve breastfeeding services. A non-competitive breastfeeding friendly grant was offered to specific birthing hospitals in targeted areas with low breastfeeding rates.

Grant opportunities will be made available to hospitals/birth centers and to community based breastfeeding coalitions to support breastfeeding activities for fiscal year 12-13.

A model hospital breastfeeding policy has been proposed for issuance by DOH. This will be a voluntary policy and the process of issuance will involve collaboration with breastfeeding stakeholders and organizations across the state.

Updates to the website included the Breastfeeding Referral Guide, and door hangers for women to utilize in hospitals while breastfeeding to indicate the desire for privacy. Presentations to healthcare professionals on a variety of breastfeeding topics have been conducted and one will be offered to human resource directors of other state agencies regarding the establishment of employee lactation rooms in their buildings.

The EPIC BEST program will begin July 1, 2012.

**c. Plan for the Coming Year**

The birthing hospital grants offered to hospitals will be implemented during the next fiscal year. These grants provide seed money for hospitals to 1) establish maternity care practices to support breastfeeding which comply with Surgeon General's Call to Action to Support Breastfeeding and 2) collaborate with their local WIC Program to increase referrals and improve continuity of care to WIC breastfeeding participants.

The EPIC BEST program will be in its second year of offering educational programs to physician office practices. The grantees of the mini grant program will be monitored for performance and the lessons they learn in their activities will be shared with other hospitals. Another round of mini grants for the hospitals and birthing centers in the state is anticipated. The Nurse Consultants will continue the Business Case for Breastfeeding as well as The Happiest Baby presentations. Additional counties will be approached about starting breastfeeding coalitions and lessons learned from the coalition mini-grants will be shared with all the local coalitions. The Department will continue its relationship with the Pennsylvania Breastfeeding Coalition. The Coordinator will continue to work closely with WIC and to reach out to hospitals and coalitions to provide needed services and support in their work to promote, protect, and support breastfeeding families.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 98 | 98 | 98.3 | 98.4 | 98.5 |
| Annual Indicator | 98.1 | 97.2 | 97.6 | 98.0 | 98.7 |
| Numerator | 143353 | 140487 | 138427 | 135732 | 136503 |
| Denominator | 146191 | 144564 | 141847 | 138541 | 138255 |
| Data Source | | See field level note | See field level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 98.6 | 98.7 | 98.7 | 98.7 | 98.7 |

**Notes - 2011**
Numerator source: Division of Newborn Screening and Genetics

Denominator source: PA Department of Health, Bureau of Health Statistics and Research

**Notes - 2010**
Numerator source: Division of Newborn Screening and Genetics

Denominator source: PA Department of Health, Bureau of Health Statistics and Research

**Notes - 2009**
Numerator source: Division of Newborn Screening and Genetics
Denominator source: PA Department of Health, Bureau of Health Statistics and Research

Calculation adjustment was made to the denominator.

**a. Last Year's Accomplishments**
In calendar year 2010, 137,610 infants were screened before hospital discharge; 98.4% passed their initial screening, 5.2% needed a re-screening, of the 5.2% needing rescreened, 88.6% received a re-screening.

In the fall of 2011, Hands and Voices Guide By Your Side of PA was started with program support. This program utilizes parents of children with hearing disabilities to serve as guides for those with newly diagnosed infants. Through a grant from HRSA, the Division was able to sponsor training to audiologists that focused on the most up-to-date techniques, equipment and developments in the field. The session was held in the Philadelphia area and attended by 43 participants.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide PCP education on newborn hearing screening diagnostic protocols and early intervention coordinator education. | | | | X |
| 2. Provide technical support to hospitals to administer pass/fail hearing screenings. | | | X | |
| 3. Provide technical support and education to audiologists to administer diagnostic exams. | | | X | |
| 4. Provide parent support through education, evaluation and development of a peer support program. | | X | | |
| 5. Provide technical support to the out of hospital birth newborn hearing screening program through site visits and education. | | | X | |
| 6. Explore expansion of the out of hospital birth newborn hearing screening program through utilization of department county and regional staff. | | | | X |
| 7. Explore expansion of the out of hospital birth newborn hearing screening program through utilization of department county and regional staff. | X | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Current year activities include continued hospital-based and out-of-hospital birth provider on-site technical assistance visits. Incorporated into these visits will be a new quality improvement component focusing on identifying areas in need to change. Program will continue to work with PA Early Intervention to develop and present training workshops to Part C, Early Intervention providers and others that focus on the importance of timely linkage to Early Intervention services consistent with the child's unique needs, family treatment preference, and local resources. A session entitled, "Serving Young Children with Unilateral and Mild Hearing Losses and their Families" is scheduled for May 8, May 9 and May 11, 2012. Program will also be initiating quarterly teleconferences with newborn screening coordinators and maternity nurses to develop and share information on hospital-based best practices

**c. Plan for the Coming Year**

Program continues to explore new strategies for its out-of-hospital hearing screening program, which includes replacing older equipment with new models that are easier to maintain and less costly to equip. Parent satisfaction surveys, as well as the Early Intervention Technical Assistance publication "Getting Started" will be updated. Additionally, Program will work closely with the PA Chapter of the American Academy of Pediatrics to review how referrals are made to audiologists as a way to improve loss to follow-up after failed hearing screenings. The website features will be updated to include capabilities of audiology centers to foster convenient access to information for parents and PCP's.

## Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 9.1 | 7.3 | 7.5 | 6.7 | 6.7 |
| Annual Indicator | 7.5 | 6.7 | 6.8 | 8.2 | |
| Numerator | 207000 | 185000 | 193000 | 226000 | |
| Denominator | 2775000 | 2775000 | 2822000 | 2747000 | |
| Data Source | | See field level note | See field level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 6.5 | 6.5 | 6.5 | 6.4 | 6.4 |

**Notes - 2011**

Data not available. The U.S. Census Bureau data for 2011 will not be available until September of 2012, so there will be a gap in our reporting on these figures.

**Notes - 2010**

Percent and denominator are from Table HI-5, Health Insurance Coverage Status and Type of Coverage by State, Children Under 18, prepared by the U.S. Census Bureau. The numerator was

calculated using the data from Table HI-5. PA has chosen to use the U.S. Census Bureau data because we believe it is the most consistent, reliable, and objective data available to us.

**Notes - 2009**
Percent and denominator are from Table HI-5, Health Insurance Coverage Status and Type of Coverage by State, Children Under 18, prepared by the U.S. Census Bureau. The numerator was calculated using the data from Table HI-5. PA has chosen to use the U.S. Census Bureau data because we believe it is the most consistent, reliable, and objective data available to us.

**a. Last Year's Accomplishments**
The 2009 performance objective for this measure was set at 7.5%. Data reported by the US Census Bureau showed 6.8% of children in Pennsylvania did not have health insurance, therefore meeting the target. The data shows between 2006 and 2007, the percent of uninsured children rose slightly from 7.3% to 7.5%. In 2007 this figure dropped to a low of 6.7%, before slightly rising to its current level.

In February 2009, additional changes to the CHIP program were affected by the passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA). CHIPRA reauthorized the program, added mechanisms for federal funding, and established many new requirements for the program. The CHIPRA requirements that received the most attention at the federal level in 2009 were:

Citizenship and Identity Verification
Express Lane Eligibility/Administrative Simplifications
Choice of Managed Care Organizations
Payments to Federally Qualified Health Centers and Rural Health Centers
Provision of Information about Dental Providers on the Insure Kids Now Web site
Mental Health Parity

Calendar year 2010 afforded the Department opportunities to work with advocates, insurers, community partners, legislators, and other stakeholders to make health insurance available and accessible to Pennsylvania's uninsured children and to further institute the processes necessary to comply with CHIPRA. It was the third full calendar year in which the Cover All Kid's expansion to eligibility was in effect; however, in the 2010 federal fiscal year, CHIP enrollment slightly deceased from 195,932 to 193,757. The Insurance Department is unclear why this is the case. During the recent period when Pa CHIP enrollment declined, Pa Medical Assistance enrollment for children increased substantially. We do not know if the decline in CHIP enrollment simply reflects a shift of children to Medical assistance due to the economic situation in Pennsylvania. The increase in Pa CHIP enrollment in the past two months may be seasonal of a reflection of improved economic circumstances, and we do not yet have the Pa Medical Assistance enrollment statistics for these two months.

The Insurance Department also notes an article published in the Health Affairs magazine in October 2010, which had been distributed by the Department of Health and Human Services during the celebration of the first anniversary of the enactment of CHIPRA. That article addressed the millions of children in the nation eligible for CHIP and Medical Assistance but not yet enrolled. It noted the substantial variations in enrollment rates across the states, and stated, "…it is not clear how much higher participation can be in the states that already have rates greater than 90 percent, given the dynamic nature of family circumstances and eligibility for public coverage." Pennsylvania is one of the states that has been so successful with CHIP enrollment that it may not be possible to increase CHIP enrollment further with traditional outreach and marketing activities.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Worked with advocates, insurers, community partners, legislators, and other stakeholders to make health insurance available and accessible to Pennsylvania's uninsured children. | | | | X |
| 2. Made referrals between CHIP and Medical Assistance as a result of the “Health Care Hand Shake” program. | | X | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
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**b. Current Activities**

With limited budget funds and an ever shifting economic climate, CHIP moved away from more traditional broad-based advertising and focused on grassroots initiatives and partnerships, as well as social media outlets, in 2011. Taking this into consideration, CHIP implemented the following tactics that focused on targeted ways to reinforce its key messages and increase enrollment:
Doctor's Office Campaign
New Collateral and Website Refresh
CHIP Impact Report
CHIP YouTube Videos
CHIP Mobile Site
HHS CHIP TV PSA and Media Buy
School Notices
Pennsylvania Farm Show
Helpline -- Connecting Citizens with CHIP and Tracking Progress
Effectiveness of Outreach

CHIP utilizes valuable data provided by its CHIP Helpline call center contractor to measure how callers hear about CHIP. The data collected shows that the CHIP website, County Assistance Offices, Web search engines (such as Google), and word of mouth referrals from friends, neighbors and family members reach the broadest audience. Flyers distributed through schools account for the largest CHIP call volume spikes in the shortest amount of time.

Overall, we continue to find that word of mouth strongly fuels citizen awareness of the program. To that end, CHIP always encourages citizens to tell family, friends, co-workers, and neighbors about the program. The results of this message are reflected in call volumes to the CHIP Helpline.

**c. Plan for the Coming Year**

A strategic marketing and outreach plan will be established and put into place for CHIP after it is known what the upcoming FY budget provides for the program.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|

| Data | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 13.7 | 13.6 | 13.5 | 20 | 19 |
| Annual Indicator | 24.2 | 25.8 | 26.8 | 26.9 | 27.3 |
| Numerator | 25337 | 28865 | 31928 | 31567 | 32810 |
| Denominator | 104699 | 111879 | 119134 | 117567 | 120182 |
| Data Source | | See field level note | See field level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 18 | 17 | 16 | 16 | 16 |

**Notes - 2011**
Source: CDC Pediatric Nutrition Surveillance System

**Notes - 2010**
Source: CDC Pediatric Nutrition Surveillance System

Future objectives will remain as stated. Staff typically incorporates objectives based on the statewide goals that WIC provides USDA for the State Plan.

**Notes - 2009**
Source: CDC Pediatric Nutrition Surveillance System

**a. Last Year's Accomplishments**
The CDC has not completed the reports for calendar year 2011, but 2010 reports show that there was effectively no change in the percent overweight and percent obese in the WIC population for 2010. The percent overweight levels for 2009 and 2010 were 14.8% and 14.9%, respectively. Percent obese remained constant at 12% for both 2009 and 2010. Pennsylvania continues to remain below the national average, which was 16.4% and 14.7% in 2010 for percent overweight and obese, respectively. WIC staff in local agencies continued to practice Guided Goal Setting throughout the course of the year, focusing discussions on specific behaviors related to eating and feeding practices and physical activity as opposed to content knowledge.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Staff training to improve counseling techniques. | | X | | |
| 2. Statewide goal to increase breastfeeding duration and exclusivity. | | X | | |
| 3. Staff training to improve assessment techniques in alignment with USDA's Value Enhanced Nutrition Assessment (VENA) initiative in WIC. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

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|---|---|---|---|---|
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Pennsylvania WIC continues to take steps to help local agency staff develop counseling skills to facilitate behavior change. This is a paradigm shift in the WIC approach that requires time to implement fully. Staff must continue to practice skills and an observational piece has been built in to our program monitoring efforts to gauge effectiveness of efforts. Policies will be updated to include language specific to the use of Guided Goal Setting in daily operations. Efforts continue to find a Learning Management System to house the eLearning modules developed by Pennsylvania WIC on conducting Value Enhanced Nutrition Assessments in WIC. A final module will be produced during the course of this federal fiscal year. Beginning in May 2012, WHO Growth Standards for infants and children less than two years of age will be used to more accurately assess growth in WIC participants. Pennsylvania WIC received a breastfeeding performance bonus award from USDA in fall 2011 for being one of 15 states with greatest improvements in breastfeeding rates. Breastfeeding continues to be an area of focus for WIC because it is an infant feeding practice that plays a role in reducing the risk of obesity in later life. Some of the funding will be used this year to increase local agency breastfeeding peer counseling activities.

**c. Plan for the Coming Year**

Pennsylvania WIC will focus efforts on improving staff skills on facilitating behavior changes during the course of WIC counseling sessions with participants. PA WIC will continue to work on a collaborative project with Penn State University's Center for Childhood Obesity Research in an effort to identify messages that will resonate with WIC parents on healthier feeding practices, and to evaluate the impact of different delivery methods for these messages. We will be working with Leeann Birch, a renowned researcher in the field of children's eating behaviors and her staff at Penn State. Local WIC agencies will assist in collecting survey data and offer WIC participants the opportunity to participate in this research project. WIC funding is not being used to conduct this study.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Annual Performance Objective | 14 | 14 | 13.4 | 13.1 | 12.8 |
| Annual Indicator | 13.8 | 13.6 | 12.9 | 12.5 | |
| Numerator | 19786 | 19395 | 18112 | 17289 | |
| Denominator | 143897 | 143099 | 140494 | 138800 | |
| Data Source | | See field level note | See field level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 12.5 | 12.2 | 11.9 | 11.8 | 11.8 |

**Notes - 2011**
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2010**
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics

**Notes - 2009**
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics

Future objectives will remain as stated. The factors that made such a decrease from 13.6 (2008) to 12.9 (2009) may not be consistent.

**a. Last Year's Accomplishments**
The annual performance objective has now been met for the last four years, and collaborative efforts with DPW have been expanded to continue to educate health-care providers to provide cessation services to Medicaid recipients and increase referrals to the PA Free Quitline.
In 2010, the DOH received Affordable Care Act funding to develop and implement two fax referral pilot programs in Pennsylvania (in the NW and NE regions of the state) to create healthcare provider referral networks and increase both the number of fax referrals and enrollment in PA Free Quitline services. The purpose of the Fax to Quit Program is to increase the likelihood of an individual successfully quitting tobacco by involving their healthcare providers in their tobacco cessation treatment. Through Fax to Quit, the healthcare provider can integrate PA Free Quitline services into their patient's treatment plan by actively referring the patient to the PA Free Quitline and receiving follow-up information regarding their patient's progress. Fax to Quit benefits the patient by helping them establish a quit date and quit plan and providing them with an assessment with personalized feedback to enhance motivation and commitment, coaching that is available seven days per week, and self-help quit guide and tailored fact sheets to help with their quit attempt. The DOH worked with the North American Quitline Consortium (NAQC), the PA Free Quitline, and other states to design an effective health care provider referral network and utilize existing partnerships to conduct an awareness education and outreach campaign to promote the pilot initiative, Fax to Quit. Four-week NRT kits (patches) were made available to tobacco users referred to the PA Free Quitline through Fax to Quit who were medically eligible and resided in the pilot regions of the state. Participating providers received fax notifications of each patient's enrollment status.

In the NE pilot, the Rural Health Corporation with ten locations covering three counties serving lower socio-economic status (SES) tobacco users was selected for the Fax to Quit pilot. Providers were trained by the NE Regional Primary Contractor (RPC) on how to conduct brief interventions with their patients, and a coordinator within the Rural Health Corporation was responsible for monitoring progress. The RPC provided on-going technical assistance as needed. During the pilot project, the Rural Health Corporation completed five hundred fax referrals with a forty percent conversion rate. Evaluation of the pilot included both process and outcome results. The NE pilot became the model to enhance and expand Fax to Quit statewide.

PA DOH identified a new Quitline operations vendor through the Request for Proposal (RFP) process. National Jewish Health (NJH) began service on July 1, 2011. National Jewish Health is contractually responsible for all operational activities, including receiving and processing all intake calls; performing a series of up to five cessation Counseling sessions; developing and selecting

educational material in support of the needs for the targeted communities, as well as for sub-groups within these populations such as pregnant callers and teens; provision of NRT for qualified callers (dependent on the budget) and providing information for program evaluation and outcomes reporting. NJH now serves ten states and several health plans

PA DOH has worked with NJH to streamline the PA Free Quitline enrollment process, provide multiple proactive coaching sessions with unlimited inbound calls as needed, and utilize participant-centered coaching sessions that are interactive, engaging and conveniently scheduled. Coaching sessions include assessment tools with personalized feedback that enhance the level of motivation and commitment, strategies for harm reduction and reducing secondhand smoke exposure and review of approved quit smoking medicines and education for their correct use. PA DOH is also tracking outcome data from an enhanced Quitline pregnancy protocol implemented by NJH in Colorado that focuses coaching sessions during the postpartum period.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Contracted with county/municipal health departments via prenatal home visiting programs to provide education concerning the risks of smoking while pregnant. | X | X | X | X |
| 2. Participated in the Pennsylvania Perinatal Partnership Collaborative (Healthy Start and Title V) on the development of prevention strategies. | | | | X |
| 3. Bureau of Health Promotion and Risk Reduction continued its Free Quitline. | X | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Fax to Quit is being implemented statewide and includes enhanced strategies to improve the effective delivery and use of cessation services as a health system intervention and creates expanded community-clinical linkages. Healthcare providers (HCP) enrolled in Fax to Quit complete two online trainings. The first training, Every Smoker, Every Time, educates healthcare providers about the health impacts of tobacco use and, utilizing the Agency for Healthcare Research and Quality (AHRQ) Clinical Practice Guidelines, trains healthcare providers on how to engage with their patients to ask, advise and refer. Successful completion provides 1 CME credit. A webinar training, developed by NJH, provides guidance on completion of the fax referral form. A standardized fax referral form is used to report specific patient information to the PA Free Quitline including best times to contact the patient, if the patient has any conditions such as pregnancy, high blood pressure or heart disease, and if the healthcare provider authorizes medical consent for the patient to receive NRT. NJH makes three attempts to reach the patient and the HPC is notified through fax-back reports to inform the HPC when the patient's intake session is completed, if the patient receives free NRT (patches) and when the patient completes counseling. Upon completion of counseling, patients can be referred to cessation resources within their local area to further assist them with quitting.

**c. Plan for the Coming Year**
PA DOH will work with RPCs and healthcare providers to expand Fax to Quit and explore recruiting healthcare providers with established Electronic Medical Record (EMR) systems for the purposes of fax referral to the PA Free Quitline. PA DOH 8 regional primary contractors (RPC) will have increased flexibility to design and customize practices and procedures to encourage strong collaborations with participating hospitals, Federally Qualified Health Centers, and public/private practices. The DOH's Tobacco Program statewide evaluator will be an integral part of the surveillance and evaluation of this program. PA DOH will continue to contract with NJH to administer, manage and evaluate the PA Free Quitline.

PA DOH will continue to target Medicaid providers to enroll in Fax to Quit, and provide presentations to Medical Directors in collaboration with DPW.

A customized protocol for pregnant women will be developed and implemented in partnership with NJH based on outcome process and data measures.

Call volume in to the Quitline doubled during the 2012 Centers for Disease Control and Prevention (CDC)'s Tips from Former Smokers campaign, and a similar campaign is planned for 2013. The DOH has taken advantage of the 2012 campaign by establishing a partnership with Christine Brader, a Pennsylvania resident featured in the national campaign, to educate Pennsylvanians about the dangers of smoking and inform them of resources available to help them be tobacco-free, including the PA Free Quitline. In May 2012, Ms. Brader participated in Pennsylvania's Advocacy Day at the State Capitol, where she shared her story with legislators, healthcare professionals and the public. Ms. Brader also participated in DOH's RPC Technical Assistance Conference in May, where she networked and shared her story with the eight RPCs and DOH staff. The PA DOH Office of Communications, NE RPC and American Cancer Society will continue to partner with Ms. Brader to conduct radio media tours, co-author op-eds in newspapers or publications and participate in several community-based events.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 6 | 5.2 | 5.1 | 5.1 | 6 |
| Annual Indicator | 5.1 | 6.2 | 6.5 | 7.8 | |
| Numerator | 47 | 57 | 61 | 71 | |
| Denominator | 926505 | 922818 | 936980 | 905066 | |
| Data Source | | See field level note | See field level note | See field level note | |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 6 | 6 | 6 | 6 | 6 |

**Notes - 2011**
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2010**
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: U.S. Census Bureau

**Notes - 2009**
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

**a. Last Year's Accomplishments**
In Pennsylvania, there are 67 counties that actively participate in a local Child Death Review (CDR) team. The teams review the deaths of individuals from birth to youth under 22 years of age. The objectives of the local CDR team review is to focus on prevention and improved agency collaboration, not to reinvestigate the death or focus on the legal aspects of the case. According to the Pennsylvania 2011 CDR Annual Report suicide deaths accounted for 53 child deaths reviewed in Pennsylvania in 2010. Suicide most frequently occurred among 20-21 year old youth (36%). The local CDR teams determined that 57% of the suicide deaths were probably preventable. Of the suicide deaths reviewed, 51% reported to have received prior mental health services, 32% were receiving mental health services at the time of death, and 19% were known to have had a history of drug abuse. Many local teams have recognized the need to focus on suicide prevention activities. These activities include: participating in the Yellow Ribbon Campaign, presenting on suicide in schools, establishing sub-review groups to specifically look at suicide prevention, developing a suicide prevention taskforce, establishing a local chapter of the American Foundation for Suicide Prevention, creating public service announcements, and distributing crisis and helpline information.

According to the National Institute for Mental Health, about eight out of every 100,000 teenagers will commit suicide. Some of the factors that increase the risk that teenagers will attempt suicide include: depression, alcohol or drug use, a family history of abuse, suicide or violence, previous suicide attempts, stressors, a recent loss such as a death, a break-up, or parents' divorce and being bullied or being a bully.

Through the Garrett Lee Smith Grant Project, the Department of Public Welfare was able to reach 1,242 children through early identification over a three-year period.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Implemented a Grant to identify of high risk youth in primary care settings. | | | X | X |
| 2. Coordinated a Suicide Prevention Conference that identified special populations at risk for suicide and identified which programs work best with certain diverse populations. | | | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
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|---|---|---|---|---|
| 10. | | | | |

**b. Current Activities**
The Division of Child and Adult Health Services is continuing to support CDR in Pennsylvania. The Division reviews the data from the local teams and will use this data in the development of suicide prevention programs.

The PA Youth Suicide Prevention Initiative continues to develop and fine-tune its five-year plan for PA regarding the prevention of youth suicide. The Initiative is focusing on strategies for communication, technical assistance, and school-based initiatives. The PA Department of Public Welfare, with support from the Departments of Health and Education, were again awarded funds under the Garrett Lee Smith Memorial Act. The goal of this grant is to continue implementation of an early identification system for youth at high risk for suicide (ages 14-24 years) within primary care medical settings in Allegheny and Westmoreland Counties in the Southwest, and Berks, Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties in the Southeast.

**c. Plan for the Coming Year**
The Division of Child and Adult Health Services will continue to support Child Death Review and the local CDR teams. Data from the CDR annual reports will be used to develop additional programming or support programs/activities implemented by the local CDR teams. The Division released an injury prevention funding opportunity to local CDR teams which would provide them with $62,500 for activities to use over a 15 month period. Applications are currently in the review process and will be awarded shortly.

The PA Department of Public Welfare, with support from the Departments of Health and Education, will continue with the implementation of the early identification system through stakeholder engagement and training to increase access to behavioral health services.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 82.5 | 82.5 | 82.7 | 82.7 | 82.9 |
| Annual Indicator | 82.1 | 77.9 | 82.2 | 86.4 | |
| Numerator | 1963 | 1893 | 1923 | 1974 | |
| Denominator | 2390 | 2430 | 2340 | 2284 | |
| Data Source | | See field level note | See field level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 82.9 | 82.9 | 82.9 | 82.9 | 86.4 |

**Notes - 2011**

Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2010**
Source: PA Department of Health, Bureau of Health Statistics and Research

**Notes - 2009**
Source: PA Department of Health, Bureau of Health Statistics and Research

**a. Last Year's Accomplishments**
Challenges persist that effect obstetrical care in the state. These challenges demonstrate a growing trend of diminished access to care for pregnant women and the need for a statewide solution to address the problem. Some factors at issue are a lack of timely access to prenatal care for certain populations, such as southeastern Pennsylvania's undocumented immigrant population, insufficient reimbursement for obstetrical services, including unfunded legislative mandates and inadequate provider networks. Obstetrician and Gynecological clinics are closing, due to financial constraints, especially in the rural and poor urban areas. With such a strong correlation between lack of prenatal care and low birth weight babies it is imperative that women, in all areas, have access to vital services.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Participated in the Pennsylvania Perinatal Partnership Collaborative (Healthy Start and Title V) to assist pregnant women and their families access social, physical and behavioral health services. | | | | X |
| 2. Contracted with County/Municipal Health Department Education Programs to provide home based education to at risk women, address individual social and emotional needs, and provide pregnancy education. | X | X | X | X |
| 3. Contracted with the County/Municipal Health Department Education programs to educate community providers about the availability of the home visiting programs. | X | X | X | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The DCAHS provides prenatal care services in an effort to increase access for low income and at-risk pregnant women. Programs are administered at the local level through the county municipal health departments. In calendar year 2011, prenatal care services were provided to 2,631 pregnant women. In addition to providing access to low income and at risk women, the DCAHS funds programs to provide prenatal services to uninsurable women in areas of the state with high concentrations of uninsurable women, specifically Montgomery and Philadelphia counties. In calendar year 2011, services were provided to 1,167 women who would otherwise be unserved. The DCAHS also provides funding for centering pregnancy programs, which have been shown to produce positive birth outcomes among participants, including full term and normal weight babies. The DCAHS continues to work with health departments in the state

impacted by the obstetrical shortages. In Montgomery County the obstetrical clinic will remain in Norristown and continue to provide services to low income and uninsurable women.

**c. Plan for the Coming Year**
The DCAHS will continue to work towards enhancing access to prenatal care for pregnant women. Funding will continue to be utilized to provide timely access to prenatal care for uninsurable women in Montgomery and Philadelphia counties. Programs such as centering pregnancy as well as programs that work from the Life Course Model will continue to be reviewed and assessed by the DCAHS. Together the local, county and state public health workforces strive to find a statewide solution to the lack of timely access to prenatal care and improve the provider networks in Pennsylvania.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 84 | 81 | 79.6 | 79.8 | 72 |
| Annual Indicator | 70.5 | 70.5 | 70.9 | 71.3 | |
| Numerator | 95605 | 97224 | 97574 | 97119 | |
| Denominator | 135683 | 137821 | 137697 | 136264 | |
| Data Source | | See field level note | See field level note | See field level note | See field level note |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 72 | 72 | 72 | 72 | 72 |

**Notes - 2011**
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2010**
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research

**Notes - 2009**
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research

**a. Last Year's Accomplishments**
Through Block Grant funds, the DCAHS continued to support various maternal and infant home visiting programs at the ten local county municipal health departments. The majority of these

health departments have home visiting programs aimed at linking pregnant and parenting women with vital services. Through these programs, pregnant women lacking prenatal care are assisted in accessing care and are provided with education on a variety of topics throughout the prenatal period. Additionally, the DCAHS provided funding to implement centering pregnancy programs in areas at a higher risk for poor birth outcomes. The program has improved prenatal care compliance among enrolled women.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Pennsylvania Perinatal Partnership Collaborative (Healthy Start and Title V) assists pregnant women and their family's access social, physical, and behavioral health services. | | | | X |
| 2. County/Municipal Health Department Education Programs provide home based education to at risk women, address individual social and emotional needs, provide pregnancy education, assess medical, financial and social situation to provide appropriate ref | X | X | X | X |
| 3. Encourage early and regular care, make educational and informational materials available to perinatal women. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The DCAHS continues to provide home visiting programs, administered through the local county municipal health departments, aimed at increasing early access to prenatal care. Home visiting programs help to link pregnant and parenting women with vital services necessary for a healthy pregnancy and a healthy life. The majority of the county municipal health departments have provided their clients with information about the Text4Baby program targeted toward new and expectant moms. The DCAHS provided funding for centering pregnancy programs which have shown improvement in prenatal care compliance among women enrolled in the program. Additionally, the DCAHS is funding centering pregnancy training programs for providers who wish to establish the initiative in their offices.

To date, 320,180 subscribers have signed up for the Text4Baby free service across the nation. More than 600 outreach partners, including national, state, business, academic, non-profit, and other groups, are helping to promote the service. PA has 13,000 women enrolled and only seven other states have higher enrollment in the program than Pennsylvania. Text4baby was utilized recently by the Centers for Disease Control and Prevention to send targeted messaging to Pennsylvania subscribers about the importance of family members getting a pertussis immunization in efforts to protect babies as Pennsylvania is one of seven states where there are reports of increased pertussis activity.

**c. Plan for the Coming Year**

The DCAHS will continue to provide home visiting programs providing prenatal services to low income and at risk pregnant women across Pennsylvania. Initiatives such as centering pregnancy programs and Life Course programs will continue to be reviewed and monitored for

positive birth outcomes among participants.

Text4Baby organizers have set a goal of reaching one million users by the end of 2012. During the next year, evaluation and refinement of the messages is planned. The Department will expand efforts to enroll mothers in the program by partnering with additional organizations.

## D. State Performance Measures

**State Performance Measure 1:** *Percent of women (15 through 44) with a live birth whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck index.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 66.9 |
| Annual Indicator | | | 66.8 | 67.9 | |
| Numerator | | | 88442 | 89153 | |
| Denominator | | | 132449 | 131353 | |
| Data Source | | | See field level note | See field level note | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 66.9 | 66.9 | 70 | 70 | 70 |

**Notes - 2011**
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2010**
Calculated with missing data (adequacy measure could not be computed) removed from denominator.
Source: PA Department of Health, Bureau of Health Statistics and Research

**Notes - 2009**
Calculated with missing data (adequacy measure could not be computed) removed from denominator.
Source: PA Department of Health, Bureau of Health Statistics and Research

**a. Last Year's Accomplishments**
The DCAHS continued to provide funding to local county municipal health departments. The county municipal health departments provide health clinics which focus on early pregnancy testing to encourage early entry into prenatal care. Women seen at the clinics with positive pregnancy tests are offered assistance with scheduling prenatal care visits.

The DCAHS funded collaboration between Drexel University School of Public Health, the Maternity Care Coalition and Thomas Jefferson University to conduct focus groups to assess barriers to accessing prenatal care in specific zip codes in Philadelphia. The findings resulted in a partnership between Albert Einstein Healthcare Network and Enon Tabernacle Baptist Church. The organizations are currently working to implement a centering pregnancy program in Philadelphia.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Deliver prenatal care to at risk women though local/county/municipal health departments | | | | X |
| 2. Integrate life course model into service contracts and grants | X | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The DCAHS provides funding towards centering pregnancy programs in Montgomery and Philadelphia counties. Centering pregnancy programs have been shown to produce positive birth outcomes among participants in areas such as prenatal care compliance, reducing preterm births, initiation of breastfeeding and maternal knowledge of pregnancy.

The county municipal health departments provide health clinics which focus on early pregnancy testing to encourage early entry into prenatal care. Women seen at the clinics with positive pregnancy tests are offered assistance with scheduling prenatal care visits. Additionally, the county municipal health departments are moving towards evidence based and best practices in their home visiting programs. The DCAHS continues to track outcome measures from these programs.

**c. Plan for the Coming Year**

The DCAHS will continue to promote early entry into prenatal care through initiatives such as home visiting programs, centering pregnancy programs and early pregnancy testing. Some of the risk factors for lack of prenatal care include giving birth before age 20, lack of a high school education, low income, and lack of proper health insurance. Programs that target individuals with these risk factors continue to need to be initiated in order to increase the number of women in both groups who seek prenatal care in their first trimester. Home visiting programs provide women continued support and health education to maintain a healthy pregnancy. The DCAHS continues to support the county municipal health departments in transitioning to evidence based programs.

MCHSBG funding will continue to be provided to assist uninsured or uninsurable women access to regular prenatal care in Montgomery and Philadelphia counties.

## State Performance Measure 2: *Black infant mortality rate per 1,000 live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 16.6 |
| Annual Indicator | | | 16.6 | 14.4 | |
| Numerator | | | 366 | 312 | |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | | | 21998 | 21632 | |
| Data Source | | | See field level note | See field level note | See field level note |
| Is the Data Provisional or Final? | | | | Final | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 16.6 | 16.5 | 16.4 | 16.4 | 14.4 |

**Notes - 2011**
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2010**
Source: PA Department of Health, Bureau of Health Statistics and Research

**Notes - 2009**
Source: PA Department of Health, Bureau of Health Statistics and Research

**a. Last Year's Accomplishments**
The Bureau continues to be concerned about the overall infant mortality rate and more specifically about the disparity in infant mortality rates among certain racial and ethnic minorities. In 2010, the Bureau identified infant mortality as a priority area for Title V. The Bureau identified areas of the Commonwealth where the infant mortality rate is particularly dire and has been developing creative strategies and interventions aimed at addressing this issue. Specific interventions include home visiting programs, prenatal care for uninsurable women, faith based initiatives, community round table discussions, community intervention grants and centering pregnancy programs.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Collaborate with non-traditional partners (ie: clergy) to reduce the incidence of black infant mortality | | | X | X |
| 2. Develop a strategic plan to reduce black infant mortality rate in zip codes with the highest incidence | | | X | X |
| 3. Implement centering pregnancy demonstration project | | | X | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Despite continued initiatives, a distinct disparity remains between the infant mortality rate (IMR) of white babies and the IMR of black babies. In 2009, the state rate of infant mortality was 7.2 per 1000 live births. The rate for black infants during the same period was 16.6 per 1000 live births. The DCAHS is working to lower the overall IMR in Pennsylvania. Specific initiatives that focus on racial disparities include the centering pregnancy program in Philadelphia in which the neighborhood was chosen specifically for this initiative due to a higher than average IMR as well as the Cribs for Kids small no bid grant program which will provide funding for ten new Cribs for Kids partners in underserved communities in Pennsylvania. Additionally, the DCAHS recently offered an opportunity for small no bid grants for community programs aimed at injury prevention.

Several funded entities included programs administering safe sleep initiatives in at-risk communities.

**c. Plan for the Coming Year**
The DCAHS will continue to work toward closing the racial gap in the IMR. S.I.D.S of PA will continue to implement the program designed to provide education and intervention related to SIDS and safe sleep practices across the Commonwealth. The most significant issues in black infant mortality exist in Pennsylvania's most populated counties. As such, the DCAHS will continue to support initiatives in Allegheny and Philadelphia specifically aimed at reducing the IMR among black infants. The DCAHS will continue to support the county municipal health departments in implementing the Life Course Model, particularly work on pre-conception and interconception health.

**State Performance Measure 3:** *Percent of women receiving WIC services screened for behavioral health concerns (through MCH consultants or state health nurses) at participating WIC clinics and/or their umbrella agencies.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 0 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | | See field level note | See field level note |
| Is the Data Provisional or Final? | | | | | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |

**Notes - 2011**
Data not available.
No reliable estimate can be provided for Annual Performance Objective. Therefore, a numeric value of zero was entered.

**Notes - 2010**
New SPM as a result of 2010 Needs Assessment. Data not available.
No reliable estimate can be provided for Annual Performance Objective. Therefore, a numeric value of zero was entered.

**a. Last Year's Accomplishments**
The DCAHS met with a number of WIC clinics who expressed an interest in participating in the initiative to provide behavioral health screenings. A screening tool, the "5 Ps" was identified as an appropriate, evidenced based screening tool. The 5 P's is an integrated screening tool which focuses on alcohol and other drug use, depression, tobacco use and domestic violence. The tool was developed by Dr. Ira Chasnoff through funding by the Maternal and Child Health Bureau of HRSA and has been used in prenatal care settings as well as other office settings where there are busy and resource challenged staff.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |

| | | | | |
|---|---|---|---|---|
| 1. Developed Logic Model | X | | | X |
| 2. Identified areas for implementation | X | | | X |
| 3. Identified screening tool | X | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The DCAHS continues to explore the best method for implementing screenings in WIC clinics. Rather than using consultants, because WIC staff often have existing relationships, it may be a better fit for WIC participants to complete the screening with WIC staff.

The DCAHS worked with the county municipal health departments and the Pennsylvania Perinatal Partnership to address the need for depression and other health screenings. As a result, the county municipal health departments are conducting depression screenings with women enrolled in home visiting programs. Women are referred, as needed, to mental health services.

**c. Plan for the Coming Year**
Working with the Division of WIC, the DCAHS will identify 3 WIC clinics to begin the pilot test for using the 5 Ps screening tool.

## State Performance Measure 4: *Rate of pregnancy per 1,000 females ages 17 and under.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 0 |
| Annual Indicator | | | 9.4 | 8.9 | |
| Numerator | | | 6187 | 5666 | |
| Denominator | | | 658400 | 637106 | |
| Data Source | | | See field level note | See field level note | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |

**Notes - 2011**
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

No reliable estimate can be provided for Annual Performance Objective. Therefore, a numeric value of zero was entered.

**Notes - 2010**
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: U.S. Census Bureau

**Notes - 2009**
Most recent year of data.
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

**a. Last Year's Accomplishments**
The Division of Child and Adult Health Services (DCAHS) received approval for the post-award state plan for the Personal Responsibility Education Program (PREP). The DCAHS issued two Requests for Applications (RFA) to select PREP implementation sites from the following facilities: 1. licensed psychiatric residential treatment facilities, 2. licensed residential substance abuse treatment programs, and 3. residential programs serving delinquent youth which includes: a. residential programs serving delinquent youth licensed by the Department of Public Welfare's Office of Children, Youth, and Families (OCYF), b. OCYF Youth Development Centers, and c. OCYF Youth Forestry Camps, 4. licensed partial hospitalization or outpatient drug and alcohol facilities, 5. licensed partial hospitalization or outpatient mental health facilities. Fifteen implementation sites were selected. PREP implementation sites will implement either the Rikers Health Advocacy Program or Street Smart. The PREP implementation sites will also be required to supplement these programs with lessons from Sex Ed 101 to address all contraception options and the adulthood preparation subjects. The three required adulthood preparation subjects are healthy life skills, healthy relationships, and adolescent development. The DCAHS issued a Request for Proposals (RFP) and selected Persad Center to provide lesbian, gay, bisexual, transgender, and questioning (LGBTQ) cultural competency training to the PREP implementation sites. The DCAHS issued a second RFP for the training and evaluation components related to PREP. The Family Planning Council was the selected vendor.

The DCAHS participated in the Pennsylvania Coalition to Prevent Teen Pregnancy Stakeholder group. The stakeholder group is working together to promote and implement the use of science-based teen pregnancy prevention programs.

The DCAHS supported the Safe Teens website, which is an interactive educational website aimed at teens to provide them with information and links to community services and resources. Over 40,000 Safe teens Web page views occurred during last year. The DCAHS supported the four family planning councils in Pennsylvania to provide reproductive health services, including contraception to youth 17 years of age and younger.

Please see National Performance Measure 8 for additional activities.

The Division of Community Systems Development and Outreach is administering the State Abstinence Education Program (SAEP). SAEP is being managed via a contract with Temple University of Pennsylvania. Management includes training facilitation, evaluation, and contract management. Promoting Health Among Teens, Abstinence Only curriculum was chosen as the curriculum to be used for abstinence education. Training of trainers of six sub grantee organization took place in the program year, with 30 individuals being trained.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Personal Responsibility Education Program in residential facilities serving delinquent youth, psychiatric residential/partial/outpatient treatment facilities, & residential/outpatient/partial drug & alcohol treatment programs | | | | X |
| 2. Safe Teens Website | | | X | |
| 3. Reproductive health services, including routine gynecological care, contraceptives, and pregnancy testing for teens under the | X | | | |

| | | | | |
|---|---|---|---|---|
| age of 17 | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The DCAHS is in the process of finalizing grant agreements with the PREP implementation sites and the DCAHS anticipates that all sites will have been trained on the appropriate curriculum and will have started implementing either Street Smart or Rikers Health Advocacy Program by late summer 2012.

The DCAHS is partnering with the Family Planning Council and Adagio Health Inc., to provide teen pregnancy prevention services. The Family Planning Council is using these funds to provide reproductive health services to high school students through the Health Resource Center (HRC) program. The HRCs provide counseling and education about abstinence, health, and sexuality, information on making responsible choices about reproductive health and relationships, STD screening and pregnancy testing, and referrals to school and community-based resources. Adagio Health Inc. is delivering two evidence based teen pregnancy prevention interventions: Focus on Kids and Reducing the Risk; to middle and high school students.

The DCAHS will continue to support the Safe Teens website and reproductive health services for youth through the four family planning councils.

Please see National Performance Measure 8 for more activities.

In SAEP, Temple University contracted with six sub grantees to provide abstinence education to over 3,800 targeted youth. Monitoring and evaluation continue in the program.

**c. Plan for the Coming Year**
The DCAHS will continue to provide programming on abstinence and contraception to prevent pregnancy and sexually transmitted infections, and three adulthood preparation subjects including: healthy relationships, adolescent development, and healthy life skills through PREP funding. PREP implementation sites will receive ongoing training on LGBTQ cultural competency and on topics related to implementing evidence-based teen pregnancy prevention programs with fidelity. The DCAHS will evaluate and conduct fidelity monitoring at each PREP implementation site on an annual basis.

The DCAHS will continue to fund the FHCCP and Adagio Health Inc. to provide the teen pregnancy prevention services listed above. The DCAHS will continue to support the Safe Teens website and reproductive health services for youth through grant agreements with the four family planning councils.

Please see National Performance Measure 8 for additional activities.

Temple University will continue to manage the SAEP. Sub grantees will continue to provide abstinence education directly to adolescents.

**State Performance Measure 5:** *Percent of infants and children (1-5) receiving WIC services screened for mental health concerns (through MCH consultants/state health nurses) at participating WIC clinics or their umbrella agencies.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 0 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | | See field level note | See field level note |
| Is the Data Provisional or Final? | | | | | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |

**Notes - 2011**
No reliable estimate can be provided for Annual Performance Objective. Therefore, a numeric value of zero was entered.

**Notes - 2010**
New SPM as a result of 2010 Needs Assessment. Data not available.
No reliable estimate can be provided for Annual Performance Objective. Therefore, a numeric value of zero was entered.

**a. Last Year's Accomplishments**
The DCAHS met with WIC clinics who expressed interest in participating in the initiative to provide mental health screenings. Appropriate screening tools were explored in conjunction with the Early Childhood Mental Health advisory committee, in Department of Public Welfare that reports to the Secretary.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Develop Logic Model | X | | | |
| 2. Identified areas for implementation | X | | | |
| 3. Identified screening tool | X | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The DCAHS has identified the Ages and Stages Questionnaire: Social Emotional (ASQ: SE) for use in screening for mental health issues in the ages of birth through 5 years. Ages and Stages includes a social, emotional section with which trained professionals can recognize young children at risk for social or emotional difficulties, identify behaviors of concern to caregivers, and identify any need for further assessment. Rather than focusing exclusively on WIC participants, the DCAHS will broaden its target group and is exploring how to make the ASQ available for all

parents. Many county municipal health departments have replaced the previous developmental tool, the Denver Developmental Screening Test, with the Ages and Stages developmental screening tool.

**c. Plan for the Coming Year**
The DCAHS will work with the developers of ASQ: SE to explore how to make the product widely available. The DCAHS will work with the Division of WIC to pilot test the ASQ: SE in at least 3 sites.

**State Performance Measure 6:** *Percent of youth serving health, mental health, and drug and alcohol clinics that target LGBTQ, runaway or homeless youth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 0 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | | See field level note | See field level note |
| Is the Data Provisional or Final? | | | | | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |

**Notes - 2011**
Data not available.
No reliable estimate can be provided for Annual Performance Objective. Therefore, a numeric value of zero was entered.

**Notes - 2010**
New SPM as a result of 2010 Needs Assessment. Data not available.
No reliable estimate can be provided for Annual Performance Objective. Therefore, a numeric value of zero was entered.

**a. Last Year's Accomplishments**
The DCAHS issued a Request for Application (RFA) to select established, youth serving, health clinics to participate in a lesbian, gay, bisexual, transgender, and questioning (LGBTQ) cultural competency assessment, goal development related to LGBTQ cultural competency and LGBTQ cultural competency training. The intent was for the DCAHS to provide funding for the health clinics to become more LGBTQ culturally competent and then do outreach to high risk youth through social media to highlight the clinics knowledge and ability to serve LGBTQ youth, leading to an increase in the number of high risk youth receiving appropriate health care services. A second RFA was issued to select the vendor who would provide those assessments and trainings to the health care clinics. The Division did not receive any applications from health clinics, and therefore both RFAs were cancelled.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Developed a logic model and program plan around this performance measure | | | | X |

| | | | | |
|---|---|---|---|---|
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The DCAHS is in the process of awarding two sole source grants. One grant will go to Persad Center and the second will go to Mazzoni Center. Persad Center will implement the Safe Spaces Project and provide the following services to high risk youth: mental health screenings, counseling, and interventions, link youth to outside services at ally agencies and organizations that are sensitive to their needs, and provide opportunities to socialize with other youth and promote positive social change.

Mazzoni Center, will provide youth drop-in services to support LGBTQ youth, which will include medical care and other support services (case management, mental health services, HIV testing and STD screening, risk-reduction counseling, and health education) to youth regardless of insurance status. Mazzoni Center will also provide cultural competency training for other service providers.

**c. Plan for the Coming Year**
The Department will continue to partner with Persad Center and Mazzoni Center to provide services for underserved youth. This will lead to an increase in the number of high risk youth receiving appropriate health care services.

**State Performance Measure 7:** *The death rate per 100,000 due to unintentional injuries among children aged 19 years and younger*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 9.6 |
| Annual Indicator | | | 9.6 | 11.1 | |
| Numerator | | | 313 | 354 | |
| Denominator | | | 3246924 | 3179390 | |
| Data Source | | | See field level note | See field level note | See field level note |
| Is the Data Provisional or Final? | | | | Final | |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 9.5 | 9.5 | 9.5 | 9.5 | 9.5 |

**Notes - 2011**
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2010**

Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: U.S. Census Bureau

**Notes - 2009**
Numerator source: PA Department of Health, Bureau of Health Statistics and Research

Denominator source: PA State Data Center

**a. Last Year's Accomplishments**
This measure was developed during the last year, based on the Title V Needs and Capacity Assessment and the priority setting that was completed related to the assessment.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Annual review of all deaths of children under the age of 21 to determine preventability (child death review process). As a result, prevention strategies are developed and implemented at the local level. | | | X | X |
| 2. Offer small no bid grants to local CDR teams focusing on prevention efforts | | | X | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Based on findings from child death reviews that are conducted by Local CDR Teams, prevention measures that vary according to the findings and local community are developed and implemented in the communities. Some of the prevention measures that have been implemented focus on motor vehicle safety, suicide prevention, safe sleep and farm safety. The intent is that prevention measures will reduce the death rate of children.

The State CDRT identified the following issues to work on in the coming year: safe sleep, infant death scene investigation, suicide, and perinatal deaths.

The DCAHS has incorporated an educational "Healthy Homes" checklist into home visits conducted for children with elevated lead levels. While the case managers are in homes, they review this checklist with families and provide education on how to identify and reduce home safety hazards, including trip or fall risks, accidental poisonings, burns, drowning, suffocation and strangulation.

**c. Plan for the Coming Year**
The Pennsylvania Public Health Child Death Review Program will continue to have participation in all 67 counties and strive to assist the Local Child Death Review teams in identifying prevention efforts at the local and state levels to assist in the reduction of child deaths. In order to promote prevention efforts at the local level, the DCAHS has awarded 18 separate no bid contracts for childhood injury prevention activities. Service to be provided through these contracts include fire

prevention, water safety, safe sleep, overdose prevention and response education, head and spinal cord injury prevention, and drug free communities programs.

The DCAHS released a funding opportunity to local CDR Teams which would provide them with $62,500 for activities to use over a 15 month period. Applications are currently in the review process and will be awarded shortly.

The CLPPP will be reestablishing priorities and strategies and will focus on activities to create safe and healthy home environments through identification of risks, education and interventions. DCAHS will provide grants to agencies who are able to incorporate home assessments and interventions with existing home visiting programs in order to identify and reduce safety hazards in at-risk populations.

**State Performance Measure 8:** *Percent of children with special health care needs (CSHCN) needing a referral for specialty care/services in the last 12 months and had no problems getting it.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 89.5 |
| Annual Indicator | | | | 82.8 | 82.8 |
| Numerator | | | | 130892 | 130892 |
| Denominator | | | | 158083 | 158083 |
| Data Source | | | | See field level note and attached White Paper | See field level note |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 82.8 | 82.8 | 82.8 | 82.8 | 82.8 |

**Notes - 2011**
Note for 2011: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. The annual performance objective for this measure has been set to match the annual indicator from 2011 and will remain at that level until another CSHCN survey is conducted.

Source for 2011: 2009/10 National Survey of Children with Special Health Care Needs

**Notes - 2010**
Note for 2011: Numerators and denominators are not available for 2011. The annual indicator for 2010, reflects the results of the latest (2009/10) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

**a. Last Year's Accomplishments**
The Bureau of Family Health's (BFH) Special Kids Network System of Care (SKN SOC) continued to provide information and referral services through its SKN SOC helpline, which operates as a statewide toll-free number through the multi-agency PA Health and Human Services Call Center (HHSCC). SKN callers had access to 27,885 services in the annually updated SKN database by phone or via a searchable database on the Web. Parents and professionals attended informational tours of the HHSCC to learn about its operation and how

they may assist in identifying resources for the database. Parents and professionals are now ambassadors for the call center and have been contributing resource information.

The BFH hired a Parent Advisor to provide input into programs, initiatives and policies from the parental perspective. The Advisor participated with the parent team for the tour of the call center and provided input both for current and future development within the center. Awareness of the one stop support system that is currently in place for parents, children with special health care needs and youth can now be spread to other parents.

In November 2011, BFH staff conducted a three day training for HHSCC phone representatives to build upon staffs' knowledge of key resources for CYSHCN and to enhance their skills in responding to families seeking information and resources. Because some callers needed help beyond what could be provided through the call center, a referral process to the PA Elks Home Service Program was developed and commenced on October 1, 2011. This arrangement was possible through a sub contract with the PA AAP. Families are referred to the Pennsylvania Elks Home Service staff from the SKN SOC helpline, Family Health Nursing Services Consultants (FHNSC), and other community-based organizations. The staff works with families in their home environment providing service coordination and distributes selected information about services and programs available through BFH. Elks Home Service staff also identify barriers to services families experience and report that information to the BFH.

Parent Youth Professional Forums (PYPF) continued to be a vehicle for guiding the BFH's resource allocation for CYSHCN. To maximize opportunities for input from the PYPFs, the BFH established a Core Leadership Team with a parent, youth, and professional representative from each of 6 regional PYPFs to create an infrastructure to address issues related to accessing information and broadly to address the 6 PYPF priorities. Through the PYPFs, parents and youth are continually exposed to information about services and programs for CYSHCN with presentations and networking opportunities.

The BFH continues to support the expansion of the Medical Home Program through a contract with the PA AAP. Pennsylvania now has 142 Medical Home Practices, up from 121 from the previous reporting period. The practices are a conduit for information about services through such mechanisms as use of a care coordinator in the practice, utilizing Parent Partners who provide resources within the practice, use of the PA Medical Home website and facebook page and holding on site and teleconferences to educate practices.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provided families information and referrals to quality services for CYSHCN | | X | | X |
| 2. Convened a Consortium for CYSHCN | | | | X |
| 3. Provided access to a care coordinator for families who are served within a pediatric medical home practices | | X | | X |
| 4. Developed and distributed public education resources on the Bureau of Family Health programs and initiatives for families of children with special health care needs. | | X | | X |
| 5. Subcontracted with the Elks Home Service Program to assist families with service coordination needs from families' home environment. | | X | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |

| | | | | |
|---|---|---|---|---|
| 10. | | | | |

**b. Current Activities**
The SKN SOC continues to make information about its scope of services available through continued involvement on interagency and inter-organization committees such as the PA Premature Infant Health Network, the Head Start Oral Health Task Force, the PA CARES TASK Force, and the State Leadership Team on Transition. The SKN SOC actively seeks opportunities to build a network of organizations that will continue, through collaboration, to improve the ease of use and access to resources for CYSHCN. Work continues with the Elks Home Service Program Care Coordination project. The SKN SOC receives monthly reports which include the identification of barriers families encounter in obtaining services for their CYSHCN. As the barriers are identified and compiled, the reports are shared internally and with the PYPF with the intent of determining the best method for arriving at a solution. The PYPFs and the PYPF Core Leadership Team continue to inform and guide the work of the SKN SOC. This work will further be defined with input from the addition of the Parent Advisor to the Bureau of Family Health.

**c. Plan for the Coming Year**
The SKN SOC will continue to seek the advice and guidance from the PYPFs, PYPF Core Leadership Team and the Parent Advisor to ensure that program resources are used to achieve the desired and applicable national and state performance measures as well as the six identified PYPF priorities.

The SKN SOC will continue to identify and improve on technologies that will enable parents, CYSHCN, and those organizations serving them to more easily access and use community-based services. SKN SOC intends to improve its website to include a robust, intuitive searchable resource database, a feature to allow communication between participants of the six regional PYPFs, and other relevant features requested by PYPF participants. Technologies such as WebEx, GoToMeetings will continue to be used to enhance opportunities for communication, education and engagement by parents and CYSHCN.

Efforts will continue to create awareness of the scope of service of the SKN SOC through greater involvement of PYPF participants, through the evolving network of community-based organizations and through inter-agency relationships.

The SKN SOC will expand the work being performed by the Elks Home Services program through its contract with the PAAAP. The current Elks Care Coordination Manager position will be responsible for responding to calls from the SKN SOC helpline. Calls will be triaged with callers being provided a range of services from information and access to resources to a referral to an Elks Home Service staff person who would work with the caller in their home environment to obtain services. The addition of a Community Systems Development component will also be included. Six positions, one each in the district health regions would be hired. A primary criterion for the position is that it is filled with a parent who has or had a child with a special health care need.

**State Performance Measure 9:** *The percentage of youth with special health care needs (YSHCN) who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 46 |
| Annual Indicator | | | | | 40.0 |
| Numerator | | | | | 78269 |
| Denominator | | | | | 195595 |
| Data Source | | | | See field level note | See field level note |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 40 | 40 | 40 | 40 | 40 |

**Notes - 2011**
Note for 2011: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. The annual performance objective for this measure has been set to match the annual indicator from 2011 and will remain at that level until another CSHCN survey is conducted.

Source for 2011: 2009/10 National Survey of Children with Special Health Care Needs

**Notes - 2010**
Note for 2011: Numerators and denominators are not available for 2011. The annual indicator for 2010, reflects the results of the latest (2009/10) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

The National Survey reflects only ages 12-17. Information for ages 14 -21 is unavailable.

**a. Last Year's Accomplishments**
The Bureau was awarded funding, Innovative Evidence Based Models for Improving the System of Services for Children and Youth with Special Health Care Needs (CYSHCN), grant in 2011 for three years. Grant funds will be used to replicate innovative evidence based models that improve services for children and youth with special health care needs transitioning to adult health care. The overarching goals for Pennsylvania include engaging pediatric practices to expand their transition protocols and policies; strengthening youth and family leadership presence and partnerships with pediatric practices and community partners; and engaging new and enhance existing community partners in the medical home efforts to address transition. Pennsylvania's initiative builds on the strong partnerships that already exists between the Bureau of Family Health and key collaborators such as PA Chapter of the American Academy of Pediatrics (Department funded PA Medical Home Program grantee), family and youth leaders, adult health care providers, the Pennsylvania Education and Advocacy Leadership Center (serving as the state's Family to family Health Information Grantee), other state agencies and federal partners.

Additional Maternal and Child Health Block Grant funding was also allocated to focus on transition by building connections with pediatric and adult practices to serve youth with special health care needs. Collaborating with the PA Chapter of the Academy of Family Physicians (PAFP), adult healthcare providers will be engaged in efforts and educated about these youth to better ensure a seamless transition from pediatric to adult health care. A care coordinator will work jointly with both the pediatric and adult practices to assist transition age youth in transitioning to adult health care providers. Best practices and lessons learned will be shared with other pediatric and adult practitioners across the state so stronger network for transitioning youth can be built.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** |
|---|---|

| | DHC | ES | PBS | IB |
|---|---|---|---|---|
| 1. Continued participation with MOU Shared Agenda on Transition with fellow Commonwealth Agencies | | | | X |
| 2. Enhanced the support of the PYPF for CYSCN and their families to provide a mechanism for communication and feedback | | | | X |
| 3. Revised and distributed the Transition Checklist: Transition to Adult Living in Pennsylvania to youth with special health care needs and their families, their schools, and their providers | | X | | X |
| 4. Developed Pennsylvania Community of Practice on Transition educational products to enhance outreach efforts and provide awareness to transition age youth with children with special health care need and their families | | X | | |
| 5. Worked with pediatric practices and adult practitioners on transition initiatives | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Currently, within the MH Program database, 3,733 (17.9%) of the 20,838 active patients have been identified as youth 18 years of age and older that are of transition age. In collaboration with the PAFP, practice dyads have been identified, with each dyad consisting of a pediatric practice and an adult practice to whom an identified youth would be transitioning. Identification of pediatric practices is moving forward however, identification of adult health care providers has been more challenging. The PAFP membership is being surveyed to determine their knowledge level, willingness and capacity to serve these youth and identify supports that may be needed. Information is being provided through newsletter articles and presentations at their conference.

A parent of a child with special health care needs was hired as Parent Coordinator for transition activities. She is working with a cadre of professionals to present webinars on a variety of topics. The Coordinator is assisting in making a Department of Public Welfare (Medicaid agency) policy more understandable for parents.

In April 2011, the first Transition Advisory Committee was convened by the MH Program broad representation including, parents and youth and young adults with complex needs, pediatric and adult health care providers, parent and youth organizations, state government and others. The committee's responsibility is to advise the MH Program about transition in Pennsylvania.

**c. Plan for the Coming Year**

Results of the survey of adult providers will be used to prepare a directory of adult health care providers that can accept youth with special health care needs. With the consent of the providers, this information will be made available to families, young adults and health care providers.

More practice dyads will be brought into the funded activities, with the intent of having dyads represented across the state.

Tools for the transition process will be developed including a resource guide, "roadmaps" to guide transfer of care from pediatric to adult health care providers and others. These will be shared

with practices in the MH Program.

**State Performance Measure 10:** *Percent of families with children with special health care needs (CSHCN) who received all the respite care that was needed during the past 12 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 59.4 |
| Annual Indicator | | | | 40.0 | 58.8 |
| Numerator | | | | 78269 | |
| Denominator | | | | 195595 | |
| Data Source | | | | See field level note | See field level note |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 58.8 | 58.8 | 58.8 | 58.8 | 58.8 |

**Notes - 2011**
Note for 2011: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. The annual performance objective for this measure has been set to match the annual indicator from 2011 and will remain at that level until another CSHCN survey is conducted.

Source for 2011: 2009/10 National Survey of Children with Special Health Care Needs

**Notes - 2010**
The annual indicator for 2010 reflects the results of the latest (2009/10) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

**a. Last Year's Accomplishments**
Pennsylvania received the Lifespan Respite Care Grant from the Administration on Aging. The Lifespan Respite Care Advisory Council worked to enhance and expand opportunities for accessing respite care across the lifespan and strengthen a currently fragmented system of the provision of respite services. The Council developed a grant program that would provide opportunities for respite care throughout the state and targeted the provision of respite for families and caregivers with unmet needs and emergency situations. The Lifespan Respite Care Advisory Council has also gathered a listing of Pennsylvania respite care providers and entered their information on the ARCH National Respite Network and Resource Center's National Respite Locator for easy accessibility for families needing respite care services. Respite care information was also housed on the Department of Aging's website as well as the Special Kids Network System of Care web portal to educate families and caregivers about the availability of respite service providers.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Participation on the Pennsylvania Lifespan Respite Grant Advisory Council to help create effective change in the way we offer respite care to families | | X | | X |

| | | | | |
|---|---|---|---|---|
| 2. Augmenting the database of providers to include additional and updated resources of respite care to those who need services | | | X | X |
| 3. Dedicated funding to support the development of training to expand respite care provision to families of children and youth with special health care needs | | X | X | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Through the BFH state priority, SKN SOC has met with key partners to discuss the proposed concept for increasing respite care services for families of CYSHCN, and explore best practice training curriculums, evidence based training models and toolkits. Funding from the MCH Block Grant will support the development of a cadre of providers of respite care for caregivers of children with special health care needs through the pilot program with up to thirty-five churches/faith-based organizations. Accumulated funds have increased the capacity to award training dollars to implement the program. This will expand the number of faith based organizations who may be trained and the number of awards that can be offered. The increase of respite care provided by or in partnership with parish nurses and others within churches/faith-based organizations will be available to families who have children with medical conditions that require a level of care beyond what a non-medically oriented volunteer could provide. A second level of care will also be developed to provide respite care for children whose medical condition does not warrant a medically trained person.

The Lifespan Respite Care Advisory Council has awarded funding to three respite care organizations for lifespan respite care services throughout the state and has applied for the Lifespan Respite Care Expansion Grant that would assist in expanding funding to additional respite care provides to increase respite care service provision.

**c. Plan for the Coming Year**

Funding for the faith based respite care training program will increase as a result of non-distributed funds for the past year. Best practice training models have been identified and additional faith based organizations have also been identified to increase the number of respite programs statewide. If awarded the Lifespan Respite Expansion Grant, the Lifespan Respite Care Advisory Council will further expand respite care services throughout the state.

## E. Health Status Indicators

Health Status Indicators 01A: The percent of live births weighing less than 2,500 grams.

While the percentage of live births resulting in a low birth weight infant in 2009 (8.4) rose slightly from that observed in 2008 (8.3), the actual number of live births born weighing less than 2,500 grams has steadily declined from 2007 to 2009. The percent went up in 2009, because the denominator (the total number of births) declined in 2009. This compares to the most recent national statistics (2007) showing that the percent of low birth weight infants was 8.2. Another explanation for this rise is that the risk factors for low birth weight may be coming more prevalent.

Some possible risk factors for mothers contributing to low birth weight infants include: poverty, lack of education, substance abuse, domestic violence, decreased age a delivery, and lack of prenatal care. Programs that target interventions designed to decrease or eliminate these risk factors continue to need to be developed. The Bureau, through its community programs, continues to emphasize the importance of early and adequate prenatal care in an effort to combat the incidence of low birth weight and very low birth weight babies. Additionally, Bureau staff continues to analyze available PRAMS date to assist in understanding factors underlying these trends.

***/2013/ For 2010, the percent of live births weighing less than 2,500 grams (low birth weight) was 8.3%. This is slightly higher than the national average of 8.2% (NCHS, 2009) and does not meet the Healthy People 2020 target of 7.8%. There has been no significant change in low birth weight rates in Pennsylvania over the last five years. Low birth weight is more common in women giving birth in their teens and women who are over 40 years of age, in women who are not married, women with less than 12 years of education, women who receive inadequate prenatal care, women who smoke, use illicit drugs, or drink alcohol, and in multiple births. Preterm births also impact the low birth weight rate. //2013//***

***/2013/ Low birth weight and short gestational age is one of the top causes of infant death in the United States. The Bureau continues to provide funding for prenatal care programs to ensure early and adequate access to prenatal care. The Bureau also provides funding for centering pregnancy programs which have been shown to produce positive birth outcomes among participants in areas such as reducing preterm births. //2013//***

Health Status Indicators 01B: The percent of live singleton births weighing less than 2,500 grams.

The percentage of live singleton births resulting in a low birth weight infant remained steady at 6.6% from 2006 to 2007. However, there was a very slight decline to 6.5% in 2008 and 2009. The number of actual singleton birth of infants weighing less than 2,500 grams has steadily declined, since 2007, along with the actual total number of births in Pennsylvania. Issues such as access to comprehensive prenatal care, substance use, race and ethnic differences can impact birth outcomes.

The Bureau, through its community programs, continues to emphasize the importance of early and adequate prenatal care in an effort to combat the incidence of low birth weight and very low birth weight babies. With the addition of more data, the Bureau staff is continuing to analyze the available PRAMS date to assist in understanding factors underlying these trends.

***/2013/ The percent of live singleton births that result in a low birth weight infant increased slightly to 6.6 % in 2010 compared to 6.5% on 2009. The national average was 6.4% (NCHS, 2009 data). Even though the actual number of low birth weight infants declined in 2010, so did the number of actual singleton births which resulted in the increased percentage. The actual number of singleton births resulting in a low birth weight infant declined by 5.2% since 2007. //2013//***

***/2013/ The Bureau continues to provide prenatal care services in an effort to increase access for low income and at-risk pregnant women. Programs are administered at the local level through the county municipal health departments. Through home visiting programs, pregnant women lacking prenatal care are assisted in accessing care. They are also provided with education on a variety of topics throughout the prenatal period to increase positive birth outcomes. //2013//***

Health Status Indicators 02A: The percent of live births weighing less than 1,500 grams.

The percentage of live births resulting in a very low birth weight infant has remained constant at 1.6 percent over the last four years (between 2006 and 2009). This is a very low percent, but risk

factors and interventions listed for Health status Indicator 01A also apply to this indicator.

***/2013/ For 2010, the percent of live births weighing less than 1,500 grams (very low birth weight) was 1.6%. This was slightly higher than the national average of 1.5% (NCHS, 2009 data). This percent does not meet the Healthy People 2020 target of 1.4%. The very low birth weight rate has remained unchanged in Pennsylvania for the last five years. //2013//***

***/2013/ Low birth weight and short gestational age is one of the top causes of infant death in the United States. The Bureau continues to provide funding for prenatal care programs to ensure early and adequate access to prenatal care. The Bureau also provides funding for centering pregnancy programs which have been shown to produce positive birth outcomes among participants in areas such as reducing preterm births. //2013//***

Health Status Indicators 02B: The percent of live singleton births weighing less than 1,500 grams.

For three of the last four years the percentage of live singleton births resulting in a very low birth weight infant was 1.2% (2006 through 2009). Some possible risk factors for mothers contributing to very low birth weight infants include: poverty, lack of education, substance abuse, domestic violence, decreased age a delivery, and lack of prenatal care.

***/2013/ For 2010, the percent of live singleton births weighing less than 1,500 grams (very low birth weight) was 1.2%. There has been no significant change in the percent of very low birth weight infants born in Pennsylvania over the last five years. //2013//***

***/2013/ The Bureau continues to provide prenatal care services in an effort to increase access for low income and at-risk pregnant women. Programs are administered at the local level through the county municipal health departments. Through home visiting programs, pregnant women lacking prenatal care are assisted in accessing care. They are also provided with education on a variety of topics, including the importance of early and adequate prenatal care, substance abuse and domestic violence, throughout the prenatal period to increase positive birth outcomes. //2013//***

Health Status Indicators 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

The 2009 death rate due to unintentional injuries among children 14 years of age and younger was 5.6 per 100,000. This represents a decline of 24.3% from the 2007 rate of 7.4 per 100,000.

In 2009-10, a total of 5 Safe Kids Pennsylvania affiliates were awarded with community mini-grants. The grants focused on the following areas: 1 All Terrain Vehicle safety, 1 farm safety, 1 bicycle safety, 2 child passenger safety.

***/2013/ The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger was 6.8 in 2010 compared to 5.6 in 2009, an increase of 21.4%. Due to the small numbers, the rate can be unstable and difficult to interpret. Motor vehicle crashes accounted for 26.5% of these deaths. Risk factors for unintentional deaths in this age group include, improper use or lack of use of vehicle restraint devices, poisonings, drowning, and falls. //2013//***

***/2013/ Through grant agreements with 10 agencies, the Childhood Lead Poisoning Prevention Program (CLPPP) has incorporated activities to identify hazards in homes that may lead to injuries, and to provide education, interventions, or referrals to reduce risks. CLPPP staff responsible for home visits have attended training in order to be able to identify safety risks and to recommend appropriate interventions. To track data on the variables collected at the home visits, Surveillance staff will be working with Bureau of Information Technology staff to implement a new or modified surveillance system. //2013//***

***/2013/ In 2010-2011, the Childhood Injury Prevention Conference was held in partnership with Safe Kids Pennsylvania. There were over 120 professionals in attendance. In addition, six web-based professional development opportunities were offered regarding the following topics: sudden infant death syndrome, data, playground safety, pedestrian safety, spectrum of prevention and grant writing. //2013//***

Health Status Indicators 03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Among children 14 years of age and younger, the death rate for unintentional injuries due to motor vehicle crashes decreased from 2.9 per 100,000 in 2006 to a low of 1.4 per 100,000 in 2008 (a decrease of 51.7%), before increasing slightly to 1.7 per 100,000 in 2009.

The Department supports development, implementation, and evaluation of local injury prevention programs with funding opportunities that promote child passenger safety. Several of the local CDR teams also focus prevention efforts on motor vehicle safety.

***/2013/ The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes has steadily increased from 1.4 in 2008 to 1.8 in 2010, representing an increase of 28.6% over the last two years. Due to the small number of deaths, the rate can be unstable and difficult to interpret. Risk factors for motor vehicle deaths in this age group include improper use of restraining devices, lack of use of restraining devices, riding with a driver who is drunk or under the influence of drugs, texting or talking on the cell phone while driving, and riding with a teenage driver. //2013//***

***/2013/ The Department has a strong partnership with the Pennsylvania Department of Transportation in promoting child passenger safety education and seat distribution statewide. //2013//***

Health Status Indicators 03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

The death rate from unintentional injuries associated with motor vehicle accidents in 2009 among adolescents 15 to 24 years of age was 16.2 per 100,000. This represents a decrease of 27.7% since 2007.

Several of the local CDR teams also focus on prevention efforts on motor vehicle safety.

***/2013/ In 2010, the death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 to 24 years was 18 compared to 16.2 in 2009. This represents an increase of 11.1%. Risk factors for motor vehicle deaths in this age group include improper use of restraining devices, lack of use of restraining devices, riding with a driver who is drunk or under the influence of drugs, texting or talking on the cell phone while driving, and riding with a teenage driver. //2013//***

***/2013/ The Violence and Injury Prevention Program (VIPP) receives funding from the CDC to address motor vehicle safety among persons ages 15 to 19. The VIPP is developing an action plan that includes evaluation of the new Graduated Driver Licensing Law as well as development of local school policies aligned with the new law. //2013//***

Health Status Indicators 04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

The rate of all nonfatal injuries among children aged 14 years and younger has dropped from

258.9 in 2005 to 228.7 in 2008. This rate is the lowest in the last four years. The Safe Kids PA Coalition and its network of local affiliated chapters and coalitions continue to develop and implement statewide and local prevention programs to address the leading causes of childhood injury hospitalizations (motor vehicles, falls, poisonings, near drownings, and bicycle/pedestrian issues). These programs appear to have raised awareness in such things as the importance of using car seats and seat belts. Also there has been an increase in programs that give away bicycle helmets to children as well as providing them with bicycle safety training. An increase in programs emphasizing water safety can contribute to a decrease in near drowning episodes. Programs such as play ground safety, can also be a reason for a decrease in the number of falls experienced by children at this age. Finally there has been an increase in programs targeting poison safety in this age group. This network is rich with passionate volunteers that have developed expertise to help communities address childhood injury issues. To further enhance this network, the Department is increasing the available funding for development, implementation, and evaluation of local injury prevention programs that will reduce the burden of injury among youth.

The rate of all nonfatal injuries among children, under the age of 15 years has dropped steadily from 260.9 in 2006 to 218.0 per 100,000 in 2009. This represents a decrease of nonfatal injuries in this age group of 16.4% over the last four years.

***/2013/ After a decrease of 16.4% from 260.9 to 218 per 100,000 population between 2006 and 2009, the rate increased by 1.7% to 221.7 in 2010. //2013//***

***/2013/ In 2010-2011, the Childhood Injury Prevention Conference was held in partnership with Safe Kids Pennsylvania. There were over 120 professionals in attendance. In addition, six web-based professional development opportunities were offered regarding the following topics: sudden infant death syndrome, data, playground safety, pedestrian safety, spectrum of prevention and grant writing. //2013//***

Health Status Indicators 04B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

In 2008, the rate of all nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger was 27.0. This shows a steady decrease from 38.9 in 2005 to the present. The Safe Kids PA Coalition and its network of local affiliated chapters and coalitions continue to develop and implement statewide and local prevention programs to address motor vehicle crashes as one of the leading causes of childhood injuries. These programs emphasize the importance of car seats for the very young children and seatbelts of the older children. These base interventions go a long way in decreasing the nonfatal injury rates due to motor vehicle crashes in this age group. This network partners with local organizations that receive federal highway funding in order to complement efforts to promote child passenger safety. To further enhance this network, the Department is increasing the available funding for development, implementation, and evaluation of local injury prevention programs that will promote child passenger safety.

There has been a steady decline in the rate of all nonfatal injuries from motor vehicle crashes among children aged 14 years and younger from 36.2 in 2006 to 26.2 per 100,000 in 2009. This represents a decrease of 27.6% over the four year period of time.

***/2013/ The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children 14 years of age and younger dropped from 36.2 in 2006 to a low of 22.9 in 2010. This represented a decrease of 36.7% over the five year period. Risk factors for motor vehicle deaths in this age group include improper use of restraining devices, lack of use of restraining devices, riding with a driver who is drunk or under the influence of drugs, riding with a teenage driver. //2013//***

***/2013/ The Department has a strong partnership with the Pennsylvania Department of Transportation in promoting child passenger safety education and seat distribution statewide. //2013//***

Health Status Indicators 04C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

The rate of all nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years has decreased from 197.4 in 2005 to 156.4 in 2008. The 2008 rate is the lowest rate in the last four years. Pennsylvania is fortunate to have a Graduated Driver Licensing system that is fair compared to national standards yet there is room for improvement to limit the number of passengers being driven by a teen driver as well as requirements for seat belt use and bans on wireless devices. Through the Department's Injury Community Planning Group, the Department of Transportation, Children's Hospital of Philadelphia, and the PA Child Death Review State Team, efforts are under way to develop a Teen Driving Safety Alliance. The purpose of the Alliance is to bring together stakeholders from local communities and statewide organizations to coordinate outreach and policy efforts that will produce a safe driving environment for all road users.

Since 2006, the rate of all nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years has decreased by 29.2%, from 199.1 per 100,000 in 2006 to 141 per 100,000 in 2009. The 2009 rate is the lowest in the last four years.

***/2013/ In 2010 the rate if all nonfatal injuries due to motor vehicle crashes among youth 15 through 24 years of age was 133.4 per 100,000. This compares to a rate of 199.1 in 2006. This is a decline of 33% in the last five years. Risk factors associated with motor vehicle deaths in this age group include driving under the influence of drugs or alcohol, texting or talking on the cell phone while driving, have an increased number of passengers in the car, excessive speed, and drowsiness. //2013//***

***/2013/ The Violence and Injury Prevention Program (VIPP) receives funding from the CDC to address motor vehicle safety among persons ages 15 to 19. The VIPP is developing an action plan that includes evaluation of the new Graduated Driver Licensing Law as well as development of local school policies aligned with the new law. //2013//***

Health Status Indicators 05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

The rate of reported cases of Chlamydia among women aged 15 to 19 has steadily increased, from 25.2 in 2005 to 27.9 in 2009. The availability of urine based amplified chlamydia testing has improved screening rates, especially among males who traditionally had to have a urethral swab utilized for testing. Clinics and physicians in the private and public sectors are more inclined to offer chlamydia testing to males and females (who are not having a tabled examination) because of ease of use. Many times, partners of infected patients in the past were presumptively treated without testing, with urine testing partners are tested as well before presumptive treatment. The STD Program at the PA Department of Health has been promoting annual screening for women at the time of annual exam and whenever getting urine pregnancy test in contracted clinics throughout PA. The STD Program has additionally reached out with campaigns to increase chlamydia screening in the private sector for young women 25 and under with outreach to members of the PA Chapter of the American Academy of Pediatrics and the PA Chapter of American College of Obstetricians and Gynecologists. With more screening, there will be an increase in reported cases of infection.

***/2013/ The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia increased from 26.1 in 2006 to 31.5 in 2010, an increase of 20.7%. Compared to***

***older adults, sexually active youth (15 through 19 years of age) and young adults (20 through 24 years of age) are at higher risk for acquiring STD's. The higher risk is due to a combination of biological, behavioral, and cultural factors, access to health care, and concerns about confidentiality. //2013//***

***/2013/ The availability of urine based amplified chlamydia testing has improved screening rates, especially among males who traditionally had to have a urethral swab utilized for testing. Clinics and physicians in the private and public sectors are more inclined to offer chlamydia testing to males and females (who are not scheduled for a tabled examination) because of convenience of urethral swabs. Many times, partners of infected patients in the past were presumptively treated without testing; the availability of urine based testing has allowed partners to be tested as well presumptively treated. The STD Program at the PA Department of Health continues to promote annual STD screening for women during the time of their annual physical examination and whenever receiving a urine pregnancy test in contracted clinics throughout PA. The STD Program collaborates with service providers that target high risk populations, such as high school students in alternative venues that result in a higher yield of positive tests. The STD Program has additionally reached out with campaigns to increase chlamydia screening in the private sector for young women 25 and under with outreach to members of the PA Chapter of the American Academy of Pediatrics and the PA Chapter of American College of Obstetricians and Gynecologists. With additional screening events to a more targeted population, there will be an increase in reported cases of infection. //2013//***

Health Status Indicators 05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

In 2008, the rate per 1,000 women aged 20 to 44 with a reported case of Chlamydia was 8.3 which is an increase from the 2005 rate of 7.1. See Health Status Indicator 5A for further information.

In 2009, the rate per 1,000 women aged 20 to 44 with a reported case of Chlamydia was 8.1. This is an increase from the 2005 rate of 7.1. See Health Status Indicator 5A for further information.

***/2013/ In 2010 the rate per 1,000 women aged 20 to 44 years with a reported case of Chlamydia was 9.1 compared to 8.1 in 2009, an increase of 12.3%. The risk factors for acquiring an STD, in the 20 to 24 age group are similar to those listed in Health Status Indicator 05A. //2013//***

Health Status Indicators 06A: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)

Based on estimates from the Pennsylvania State Data Center, there were 4,149,899 children and adolescents under the age of 25 residing in Pennsylvania in 2009. Of these, 81.5% are white, 13.6% are African American, 2.7% are Asian, and 2.3% were classified as other/unknown race. The distribution of children and adolescents has changed very little since the last reporting period. Infants less than 1 year of age (3.7%) comprised the smallest percentage of this population, followed by children 1 to 4 years of age (14.3%) and children 5 to 9 years of age (18.4%). Adolescents 10 to 14 years of age accounted for 19.5 percent of the population less than 25 years of age, while those 15 to 19 years of age and those 20 to 24 years of age accounted for 22.5% and 21.6%, respectively.

***/2013/ Based on estimates from the Pennsylvania State Data Center, there were 4,053,536 children and adolescents under the age of 25 residing in Pennsylvania in 2010. A decrease of 2.3% from the total population estimates for this age group compared to 2009 estimates. Of these, 75.5% are white, 13.7% are African American, 3.1% are Asian, and 7.6% were***

***other/unknown race. The distribution of children and adolescents has changed very little since the last reporting period. Infants less than 1 year of age (3.5%) comprised the smallest percentage of this population, followed by children 1 to 4 years of age (14.5%) and children 5 to 9 years of age (18.6%). Adolescents 10 to 14 years of age accounted for 19.5% of the population less than 25 years of age, while those 15 to 19 years of age and those 20 to 24 years of age accounted for 22.3% and 21.6%, respectively. //2013//***

Health Status Indicators 06B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)

The age distributions of the Hispanic (which can be of any race) population deviated slightly from those seen for the state as a whole and has remained fairly consistent since the last reporting period. For 2009, 7.1% (327,878) of Pennsylvania residents under 25 years of age were Hispanic/Latina. Approximately 23% of the Hispanic population under 25 years of age was accounted for by infants and children under 5 years of age, while a smaller percentage was accounted for by those 20 to 24 years of age (17%). This indicates that the demographics of the childhood population is shifting toward more ethnic minorities and culturally-sensitive and linguistically-sensitive public health interventions are needed.

***/2013/ For 2010, 8.8% (357,246) of Pennsylvania residents less than 25 years of age were Hispanic/Latina. This represents an increase of 8.9% over 2009 estimates. The proportion of Hispanics by age group are as follows: Hispanic infants less than 1 year of age accounted for 4.4% of the Hispanic population under the age of 25, followed by children 1 to 4 years of age (17.9%) and children 5 to 9 years of age (9.6%). Hispanic adolescents 10 to 14 years of age accounted for 18.8% of the population in this age group, while those 15 to 19 years of age and those 20 to 24 years of age accounted for 19.9% and 7.7%, respectively. //2013//***

Health Status Indicators 07A: Live births to women (of all ages) enumerated by maternal age and race. (Demographics)

In 2009, there were 145,392 resident live births reported (excluding women of unknown age giving birth). This represents a decrease of 2.3% from 2008. The majority of these live births in 2009 occurred among White women (71.6%), followed by Black women (15.1%), Asian/Pacific Islander women (3.8%), and Other/unknown race (9.7%), 8.9% were infants born to women under 20 years of age, 76.3% to women 20 to 34 years of age, and 14.8% to women 35 years of age and older. These data indicate that culturally-sensitive messages also need to be age-appropriate, in which messages to Black/African American mothers should be directed at younger ages, while messages to other race groups should be directed to older age groups.

***/2013/ In 2010, there were 142,285 resident live births reported (excluding women of unknown age giving birth). This represents a decrease of 2.1% from 2009. The majority of these live births in 2010 occurred among White women (71.7%), followed by Black women (15.2%), Asian/Pacific Islander women (3.7%), and Other/unknown race (9.4%). Infants born to women who were under 20 years of age represented 8.5% of all births, 77% of all births were born to women 20 to 34 years of age, and 14.5% to women 35 years of age and older. For women who gave birth under the age of 20 years, 50.6% were white compared to 31% who were Black. Blacks succeeded whites in only one category (<15 years of age), where Blacks accounted for 47.7% of births compared to 27.5% for Whites. Other race categories accounted for the rest of the births in this age category. //2013//***

Health Status Indicators 07B: Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)

Hispanic (which can be of any race) women accounted for 9.3% of these resident live births. Eighteen percent of the live births in 2008 to Hispanic women were to adolescents less than 20

years of age, 73% to Hispanic women 20 to 34 years of age, and only 9% to Hispanic women 35 years of age and older.

Of the 145,392 live births to Pennsylvania mothers in 2009, 9.6% (13,996) were Hispanic/Latina, 89.2% (129,749) were not Hispanic/Latina infants, and 1.2% did not report ethnicity. In 2009, 18% of lives births to Hispanic women were to adolescents less than 20 years of age, 73% to Hispanic women 20 to 34 years of age, and only 9% to Hispanic women 35 years of age and older. This represents very little change in the demographic distribution from the last reporting period. These data indicate that culturally-sensitive messages to Hispanic/Latino mothers need to include messages to teens.

***/2013/ Of the 142,285 live births to Pennsylvania mothers in 2010, 9.6% (13,639) were Hispanic/Latino, 89.3% (127,131) were not Hispanic/Latino and 1.1% did not report ethnicity. In 2010, 16.8% of live births to Hispanic/Latino women were born to adolescents less than 20 years of age. This compares to 7.5% of non-Hispanic/Latino women who gave birth under the age of 20 years old. This is a slight decrease from 2009; 74% were born to women 20-34 years of age and; 9.3% were born to mothers 35 years of age and older. Overall, there has been no significant change in the age distribution over last year. //2013//***

Health Status Indicators 08A: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)

In 2009, there were 2,574 deaths among infants and children aged 0 through 24 years. Over 40% of these deaths were among infants, followed by 30.1% among youth aged 20 through 24 and 16.7% among youth aged 15 through 19. Children aged 1 through 4 accounted for 5.4% and children aged 10 through 14 accounted for 4.1% of these deaths. Only 3.2% of these deaths were among children aged 5 through 9. Whites accounted for 68.7% of these deaths, Blacks accounted for 28.4% and Asian/Pacific Islanders for only 1.5%.

***/2013/ In 2010, there were a total of 2,624 deaths between the ages of birth through 24 years of age. The distribution of deaths for those individuals under the age of 25 years was very similar to 2009. Deaths among infants less than one year of age accounted for 39.4% of all of the death in those under the age of 25, followed by the 20 to 24 age group (31.6%), those 15 to 19 years of age (17.5%), children 1 to 4 years of age (4.8%), the 10-14 age group(4%) and the 5-9 age group (2.6%). Whites accounted for 68.6% of all deaths in the 0 through 24 year age group, followed by Blacks with 27.2%, and Asians with 1.6%. Blacks had a higher percentage of deaths under the age of one year compared to Whites (43.7% versus 36.5%).***

***The three largest categories in Pennsylvania child deaths are natural, accidental and homicide. Together they account for 91% of child fatalities. Seventy four percent (74%) of the natural deaths occurred in infants (children less than one year of age). The most frequent cause of death among infant natural deaths was prematurity at 58%.***

***Of accidental deaths, 54% reported the cause of death to be motor vehicle or other transport. Thirty two percent (32%) of all child accident deaths were in children 15 -- 19 years of age. Of children ages 1 through 9, the most frequent causes of accidental death were motor vehicle (48%), fire, burn or electrocution (20%) and drowning (18%). In 77% of the fire related deaths, a smoke detector was present in the home and working.***

***Of homicide deaths, the primary cause of death was weapon-related (89%). Nearly half (45%) of homicide deaths occurred in 15 -- 19 year olds. //2013//***

Health Status Indicators 08B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

Over 93% of deaths among infants and children aged 0 through 24 years were Non-Hispanic residents compared to 6.5% of Hispanic (which can be of any race) residents. Of the deaths reviewed as part of the CDR process, 8.4% were reported as Hispanic/Latino ethnicity. Sixty nine percent (69%) of the Hispanic/Latino deaths reviewed occurred in children under the age of one.

Fifty four percent (54%) of the Hispanic/Latino deaths reviewed occurred in children under the age of one. Fifty two percent (52%) of the Hispanic/Latino deaths reviewed were Hispanic/Latino males.

***/2013/ Overall 89.9% of all deaths among infants and children 0 through 24 years of age were Non-Hispanics compared to 8.2% that were of Hispanic (can be of any race) origin. Ethnicity for 1.9% of all deaths was not listed. Fifty-three percent of the Hispanic/Latino deaths reviewed occurred in children under the age of one year old compared to 37.4% for non-Hispanics.***

***Of the deaths reviewed as part of the Child Death Review process, 12% were reported as Hispanic/Latino ethnicity. Fifty eight percent (58%) of the Hispanic/Latino child deaths were male. //2013//***

Health Status Indicators 09A: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)

Based on estimates from the Pennsylvania State Data Center, there were 3,246,924 individuals 0 to 19 years old residing in Pennsylvania in 2009 White/Caucasian accounted for 81.3% of this population, Black/African American for 13.6% and Asian/Pacific Islanders for 2.7%. Of this population 7.5% were enrolled in the Temporary Assistance for Needy Families program, which was consistent with the previous two year (7.5% and 7.6% respectively). Among children living in TANF families, 3.3% were White/Caucasian, while 25.9% were Black/African American.

Enrollment figures for Medicaid, SCHIP, and the food stamp program all increased over the past two years for this population. However, the number living in foster home care, the rate of juvenile crime arrests decreased for this population. The percent of high school dropouts in the state rose from 2.3% in 2008 to 2.7% in 2009. Among high school dropouts, 6.2% were Black/African American, 2.9% were Native Indian, and 1.6% was White/Caucasian. These data indicate the children living in high risk households in the state are more likely to be of minority race, and emphasize the need for culturally-sensitive interventions.

***/2013/ Based on the estimates from the Pennsylvania State Data Center, there were 3,179,390 individuals 0 to 19 years of age residing in Pennsylvania in 2010. This was a decrease of 2.1% from 2009 to 2010. Whites accounted for 75.1% in 2010 (compared to 81.3% in 2009), Blacks for 13.8% (compared to 13.6% in 2009), and Asian/Pacific Islanders for 3% (compared to 2.7% in 2009). Of this population 7.7% were enrolled in the Temporary Assistance for Needy Families (compared to 7.5% in 2009). Blacks had a significantly greater percentage of children living in TANF families than Whites (26.3% of Blacks compared to 3.6% of Whites). These numbers were slightly increased over the 2009 data.***

***The rate of juvenile crime arrests for this age group declined by 5.9% between 2009 and 2010. Declines were observed across all race categories during this time period.***

***Enrollment figures for the food stamp program, SCHIP, and Medicaid all increased again in 2010. The high school dropout rate for students in grades 9 thought 12 appeared to decrease slightly from 2.7% in 2009 to 2.0% in 2010. Among high school dropouts, rates for Blacks decrease from 6.2% to 3.4%, Whites from 1.6% to 1.5% and Asian by from 1.8% to 0.9% in the same time period (2009 to 2010). Native Americans were the only group to show a slight increase during this time period from 2.9% to 3.1%. //2013//***

Health Status Indicators 09B: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)

For Hispanics/Latinos, the percent of this population enrolled in the Temporary Assistance for Needy Families program has shown a steady decline from 18.8% in 2007 to 15.7% in 2010. The high school drop-out rate for Hispanics rose slightly from 6.7% in 2007 to 6.9% in 2008. The juvenile crime arrests rate for Hispanics/Latinos dropped by 7.5% from 2007 to 2010. The biggest increase for this group was enrollment in the number of Hispanic/Latinos enrolled in the SCHIP program. Enrollment increased by 121% from 2008 to 2010.

***/2013/ For Hispanics/Latinos, the percent of this population enrolled in the Temporary Assistance for Needy Families (TANF) program has continued to decrease from 18.8% in 2007 to 15% in 2010-11. The juvenile crime arrest rate for Hispanics/Latinos also decrease by 33.1% from 2008 to 2010. The high school dropout rate decreased significantly from 6.9% in 2009 to 4.6% in 2010. However, the numbers of Hispanics/Latinos enrolled in the SCHIP program increased by 32.9% between 2010 and 2011. //2013//***

Health Status Indicators 10: Geographic living area for all children aged 0 through 19 years.

In 2009, 88.9% of the childhood population less than 20 years of age resided in an urban area of the state, with the remaining 11.1% living in rural areas. These percentage estimates signify little change in the geographic distribution of the specified childhood population from the previous year.

***/2013/ In 2010, 73.6% of Pennsylvanians under the age of 20 years old resided in an urban area of the state, with the remaining 26.4% living in rural areas. Since the source of the data for 2010 was different from the source used in 2009, the data cannot be compared, because the definitions of what constitutes an urban versus rural area were different depending on the source that was used. //2013//***

Health Status Indicators 11: Percent of the State population at various levels of the federal poverty level.

Based on data from the American Community Survey, an estimated 5.5% of Pennsylvania's population was living below 50% of the federal poverty level, 12.5% was living below the 100% federal poverty level, and 29.2% was living below the 200% federal poverty level. These numbers represent a slight increase in all levels from the previous reporting year.

Poverty is highly associated with poor health outcomes, especially for women and children. Poverty is most common in families headed up by single females. Single female headed households with children are more likely than other families to be living below the poverty level. This is true regardless of race and ethnicity.

***/2013/ According to data from the American Community Survey, in 2010, an estimated 5.9% of Pennsylvania's population were living below the 50% federal poverty level (compared to 5.5% in 2009), 13.4% were living below the 100% federal poverty level (compared to 12.5% in 2009), and 30.7% were living below the 200% federal poverty level (compared to 29.2% in 2009). //2013//***

Health Status Indicators 12: Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.

Based on data from the American Community Survey, an estimated 7.6% of the Pennsylvania

household population under the age of 20 was living below the 50% poverty level, 17.1% was below the 100% federal poverty level, and 37.6% was living below the 200% poverty level. These figures represent a slight increase at all levels from the previous reporting year.

***/2013/ Based on the American Community Survey, in 2010, an estimated 8.4% of Pennsylvania population under the age of 20 years old were living below the 50% federal poverty level (compared to 7.6% in 2009), 19.1% were below the 100% federal poverty level (compared to 17.1% in 2009), and 39.4% were living below the 200% federal poverty level (compared to 37.6% in 2009). //2013//***

## F. Other Program Activities

The Department is challenged with developing a statewide public health approach to the provision of genetic services. The opportunities and challenges posed by advances in human genetics on public health practice bring into focus the fact that much of public health training, infrastructure, policy, and program development have not taken genetics into consideration. The Department proposes to shift the current paradigm for delivery of genetic services from one of direct service to a more collaborative public health initiative that emphasizes prevention and integrates genetics into public health practices and policies. Future activities for genetics in public health will refocus to address modifiable risk factors for disease to help target preventive interventions. The genetics program will work with other bureaus and programs within the Department to bring the genetics and public health communities together to more effectively educate professionals and the general public about the impact of genetic issues on the health of the general population, and to translate new knowledge of genetics into actions that will improve the public's health. During the fall of 2010, the Department will begin an RFA process to solicit applications to provide a public health approach to genetic services to residents within identified geographic regions and coordinate efforts with other regions to develop statewide comprehensive services for all Pennsylvania residents.
/2012/ The primary goal of this RFA is to promote the Health Resources and Services Administration's (HRSA) Genetic Services Branch program's concept of increasing knowledge of the genetic contribution to health and disease; facilitate the early identification of individuals with heritable conditions and integrate them into existing systems of care that are comprehensive, accessible, available, affordable, acceptable, population and community-based, culturally appropriate and family-centered; as well as reduce duplication and fragmentation of services. //2012//

/2012/ The Department received a grant from HRSA for Universal newborn hearing screening and intervention to cover the costs of two training contracts with the PA Chapter of the American Academy of Pediatrics and Early Intervention Services. Additionally, at the National Early Hearing Detection and Intervention conference held in Atlanta in February 2011, the program received the Website of the year award for its work on the www.paearlyhearing.org website.

For Women with Phenylketonuria who are pregnant or pursuing pregnancy, the Newborn Screening Follow-up metabolic formula program provides formula as needed for these women with a doctor's prescription and through an annual application process.

The Division of Women, Infants and Children (WIC) staff were trained using a statewide curriculum designed to improve their counseling skills to market the WIC breast pump program and the exclusively breastfeeding food packages. With the increased pump funding, many agencies also increased the number of hospital grade rentals to better accommodate mothers' needs. Due to problems with data entry, it is not possible to evaluate the impact that these measures have had on increasing breastfeeding duration. However, between April, 2010 and October, 2011, WIC experienced the largest single increase in breastfeeding incidence within a given time frame, from 46.7% to 49%.

Division of Community Systems Development and Outreach (CSDO) Staff held a discussion on HHSCC information and referral services options with the bureau's Genetics Counseling program and the DPW Bureau of Autism Services, both of which are considering use of the SKN-SOC helpline and the fulfillment center. HHSCC has the capacity to expand MCH services without additional cost.

Current CSDO plans include working with Division of WIC and the DOH Community Nursing Consultants to update the Breastfeeding Resource Referral Guide and to make it available on the DOH intranet for the public and HHSCC Lactation Specialists. CSDO is also exploring methods for increasing use of the HelpinPA website, fulfillment center, and Facebook page to promote bureau MCH programs; increasing use of the HHSCC's cost-efficient I&RS services; and, utilizing low-to-no cost outreach and advertising methods to promote the helplines and bureau programs to increase awareness and access to comprehensive information on services and programs for MCH/SHCN. With seven of the nine helplines being DOH-funded, and a range of bureau programs utilizing the HHSCC for information distribution, coordination of bureau-wide promotions is another option being explored.

To promote the Parent Youth Professional Forums (PYPF) in assisting the bureau in developing a better system of care, the HHSCC HelpinPA Facebook page publicized 16 PYPF events. In response to the PYPF request for priority actions [specifically, "Finding information and resources for CYSHCN that is easily accessible for parents, youth and professionals"], a meeting with BFH and HHSCC staff will be scheduled with up to ten PYPF representatives attending. There are several access points for CYSHCN information, including the HelpinPA website, www.helpinpa.state.pa.us and System of Care web portal, www.gotoskn.state.pa.us.

In response to the PYPF's overarching priority request, "BFH should engage in self-assessment for cultural competence," the Bureau has identified a self-assessment and roadmap tool to determine its own level of cultural competence and areas for improvement. The Bureau also hopes to adopt curricula to instill aspects of cultural competence within contracted services such as the DOH helplines.

In an effort to combat the ongoing prevalence rate of children born with a FASD, BDAP and its collaborative partners such as BFH and DPW participate in awareness activities across the Commonwealth in conjunction with National (FASD) Awareness Day, which is observed on September 9th annually. Pennsylvania's events comprise the entire week and focus on getting the message out that there is no safe amount of alcohol use during any time of pregnancy; if a woman is pregnant, she should not drink and if she drinks, she should avoid becoming pregnant. This message coincides with the Department's overall view of health promotion and disease prevention and focuses on the well-being of the children and adults throughout the Commonwealth. //2012//

## G. Technical Assistance

The NSFP requests technical assistance for data management. With the implementation of OZ eSP for reporting and follow up processes, the program is looking for use cases for data management. Program is interested in the use of other data tools useful to match resources with need (i.e.GIS mapping to look at clustering of conditions and geographic location of treatment).

Pennsylvania would like to establish a Birth Defects Surveillance Program. The Program would use data for services planning and evaluation, for development and evaluation of prevention strategies, to inform parents of children with birth defects about available services, for studies of the societal impact of birth defects, for referral of families to needed services and resources, and for clinical research studies. This Program would be a unique tool to benefit all related programs in the quest to improve the public's health. Technical Assistance is needed to establish goals and

objectives for how data are to be collected, analyzed, disseminated and used.

As a Title V agency, transition activities for CYSHCN are funded, but only until a child reaches adulthood. At that time, the funding stream for CYSHCN is no longer applicable. However, programs are not responsive to the needs of young adults with behavioral, intellectual and physical disabilities if they do not have programs in place to accept them once they turn 21. An example is Medical Home. The Bureau funds a pediatric medical home program but that is not in effect once a child turns 21, nor is it appropriate or acceptable for a 21 year old young adult to be treated in a pediatric office. Training for adult medical homes for individuals with disabilities were funded by the Developmental Disabilities Council and that grant funding expired after 5 successful years. Technical assistance is needed to explore and identify mechanisms for expanding and implementing this type of training program under the auspice of Title V.

# V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|---|---|---|---|---|---|
| | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **1. Federal Allocation** *(Line1, Form 2)* | 24390794 | 24147277 | 24121972 | | 24147277 | |
| **2. Unobligated Balance** *(Line2, Form 2)* | 0 | 0 | 0 | | 0 | |
| **3. State Funds** *(Line3, Form 2)* | 63801000 | 58568197 | 57670000 | | 57474000 | |
| **4. Local MCH Funds** *(Line4, Form 2)* | 0 | 0 | 0 | | 0 | |
| **5. Other Funds** *(Line5, Form 2)* | 0 | 0 | 0 | | 0 | |
| **6. Program Income** *(Line6, Form 2)* | 0 | 0 | 0 | | 0 | |
| **7. Subtotal** | 88191794 | 82715474 | 81791972 | | 81621277 | |
| **8. Other Federal Funds** *(Line10, Form 2)* | 220257285 | 222733231 | 229374039 | | 234180272 | |
| **9. Total** *(Line11, Form 2)* | 308449079 | 305448705 | 311166011 | | 315801549 | |

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|---|---|---|---|---|---|
| **I. Federal-State MCH Block Grant Partnership** | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **a. Pregnant Women** | 2352733 | 3188604 | 3594900 | | 2770012 | |
| **b. Infants < 1 year old** | 6937465 | 5588698 | 4596100 | | 6260461 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **c. Children 1 to 22 years old** | 45454277 | 45762047 | 45478000 | | 47442460 | |
| **d. Children with Special Healthcare Needs** | 12500225 | 11145505 | 10062584 | | 8555851 | |
| **e. Others** | 18542300 | 14970857 | 15762416 | | 14262901 | |
| **f. Administration** | 2404794 | 2059763 | 2297972 | | 2329592 | |
| **g. SUBTOTAL** | 88191794 | 82715474 | 81791972 | | 81621277 | |
| **II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).** | | | | | | |
| **a. SPRANS** | 0 | | 0 | | 0 | |
| **b. SSDI** | 141713 | | 136966 | | 65357 | |
| **c. CISS** | 0 | | 0 | | 0 | |
| **d. Abstinence Education** | 0 | | 1642951 | | 1527137 | |
| **e. Healthy Start** | 0 | | 0 | | 0 | |
| **f. EMSC** | 0 | | 0 | | 0 | |
| **g. WIC** | 212390947 | | 217856904 | | 224949696 | |
| **h. AIDS** | 0 | | 0 | | 0 | |
| **i. CDC** | 1331172 | | 1285056 | | 728828 | |
| **j. Education** | 0 | | 0 | | 0 | |
| **k. Home Visiting** | 0 | | 0 | | 0 | |
| **k. Other** | | | | | | |
| **EPA** | 281453 | | 540544 | | 799635 | |
| **HUD** | 3945000 | | 3945000 | | 2480000 | |
| **MA Lead/NBS** | 1217000 | | 1017000 | | 979000 | |
| **NBHS** | 150000 | | 328700 | | 279440 | |
| **State Impl CSHCN** | 0 | | 0 | | 86500 | |
| **State Per Ed. Prg** | 0 | | 0 | | 2034679 | |
| **Traumatic Brain Inju** | 0 | | 0 | | 250000 | |
| **State Implem CSHCN** | 0 | | 324583 | | 0 | |
| **State Per Resp Educ** | 0 | | 2046335 | | 0 | |
| **Traumatic Brain Inj** | 0 | | 250000 | | 0 | |
| **1st Time Mother/NPI** | 250000 | | 0 | | 0 | |
| **St. Implem. CSHCN** | 300000 | | 0 | | 0 | |
| **Traumatic Brain Inj.** | 250000 | | 0 | | 0 | |

**Form 5, State Title V Program Budget and Expenditures by Types of Services (II)**

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|---|---|---|---|---|---|
| | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **I. Direct Health Care Services** | 24443921 | 20486180 | 21178116 | | 18067284 | |
| **II. Enabling Services** | 1787639 | 2832439 | 1162494 | | 1359789 | |
| **III. Population-Based Services** | 47479469 | 45106443 | 46755846 | | 47259393 | |
| **IV. Infrastructure Building Services** | 14480765 | 14290412 | 12695516 | | 14934811 | |
| **V. Federal-State Title V Block Grant Partnership Total** | 88191794 | 82715474 | 81791972 | | 81621277 | |

## A. Expenditures

Form 3 (State Maternal and Child Health Funding Profile), Form 4 (Budget Details by Types of Individuals Served and Sources of Other Federal Funds), and Form 5 (State Title V Program Budget and Expenditures) have been completed in accordance with the guidance.

## B. Budget

3.3.1 Completion of Budget Forms

Form 2 (Maternal and Child Health Budget Details for FY 2012), Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Types of Individuals Served and Sources of Other Federal Funds), and Form 5 (State Title V Program Budget and Expenditures by Types of Service) have been completed.

3.3.2 Other Requirements

Pennsylvania's proposed budget for Federal Fiscal Year 2013 is in full compliance with the federally mandated "30%-30%" requirements. Of Pennsylvania's proposed federal grant award for 2013, $13,966,977 is designated for the support of preventive and primary services for children, and $7,850,708 is designated for the support of services for children with special health care needs. Following is a summary of the utilization of available funds.

Administrative Costs

Section 505 of the Maternal and Child Health Services Block Grant (MCHSBG) legislation limits the amount of the State's allocation that can be used for administration to not more than 10 percent. In FFY 2013, Pennsylvania plans to expend $2,329,592 or 9.65 percent for administration. The following is the definition of Administrative Costs used by the Pennsylvania Department of Health in administering the MCHSBG.

1. Personnel Costs
Personnel costs, including salaries and associated fringe benefits, are considered administrative if those costs are not incurred in the direct or indirect provision of prevention, education, intervention, or treatment services.

All personnel costs not included in this definition would be considered program and would not fall under the block grant administrative costs restriction.

2. Operational Costs
Operational costs are considered administrative if they are not required for the delivery of direct or indirect program services. Operational costs are considered program if they are utilized to

support program-designated activities. The designations are by minor object of expenditure.

Maintenance of Effort Match

Section 505 of the MCHSBG legislation requires that a State receiving funds shall maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level that the State provided for such programs in fiscal year 1989.

Pennsylvania bases maintenance of effort on a federal fiscal year, only including those state appropriations which are solely used for MCH; i.e., 100 percent MCH-related. In Federal Fiscal Year 1989, Pennsylvania's maintenance of effort was $20,065,574.58, as detailed below in Table 2. For Federal Fiscal Year 2013, Pennsylvania's match will exceed the 1989 maintenance of effort level. The proposed expenditure of state Maintenance of Effort for 2013 is detailed below in Table 3.

Table 2
Maintenance of Effort (Match)
Federal Fiscal Year 1989

State Funded Appropriations Amount
108 School Health Services $17,265,914.86
112 Maternal and Child Health $1,661,120.00
120 Sickle Cell Summer Camps $35,000.00
137 Tourette Syndrome $100,000.00
164 Home Ventilators $1,003,539.72
TOTAL $20,065,574.58

Table 3
Planned Maintenance of Effort (Match)
Federal Fiscal Year 2013

State Funded Appropriations Amount
108 (10654) School Health Services $36,620,000
112 (10651) Maternal and Child Health $822,000
TOTAL $37,442,000

Note: Consistently, since 1989, the BFH has used a constant set of appropriations to indicate our maintenance of effort match.

## VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. Technical Note
Please refer to Section IX of the Guidance.

## X. Appendices and State Supporting documents
### A. Needs Assessment
Please refer to Section II attachments, if provided.

### B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

### C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

### D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.